



SPINAL CORD INJURY and DISORDERS OUTCOMES INTERIM USER MANUAL



Version 3.0
May 2011

Department of Veterans Affairs
Office of Enterprise Development

Revision History

Date	Version	Description	Author/Project Manager
5/16/2011	3.0	Minor updates – vdl publication	REDACTED
9/14/2010	3.0	Update – Product Support Review	REDACTED
6/21/2010	3.0	Update	REDACTED
11/13/2009	3.0	Update per WPR	REDACTED
08/07/2009	3.0	Inserted a Note in Tab Header and Patient Lookup paragraphs that Date of Birth does not display in SCIDO or in Patient Service Lookup for Veteran employees	REDACTED
02/02/2009	3.0	Update	REDACTED
06/21/2007	3.0	Updated	REDACTED
02/05/2007			REDACTED
01/15/2007		Corrections	REDACTED
06/16/2006		Corrections, reformatted manual.	REDACTED
09/16/2005		Revisions	REDACTED
09/12/2003		Create draft	REDACTED

INTRODUCTION.....	1
Recommended Users.....	1
Related Manuals or Documents	1
VistA Document Library.....	1
Section 508 Compliance.....	1
VA Service Desk.....	1
OVERVIEW AND FEATURES.....	2
Subject Tabs	2
Tab Header	3
Buttons Used on Tabs	4
Instruments.....	7
ACCESSING THE SYSTEM	9
Logging In.....	9
Patient Lookup	9
COVER SHEET TAB.....	12
REGISTRATION TAB	13
Registering a Patient	13
Registration Tab Information	13
Registration and Network Status Section.....	14
ASIA Information Section	14
Primary Care Information Section	16
Etiology Information Section.....	16
Annual Evaluation Information Section.....	18
Registration Additional Information	18
Registration Display Information.....	21
EPISODES OF CARE	23
Episode of Care Management	23
Current Open Episode of Care	24
Create a New Episode of Care	24
Closing an Episode of Care.....	25
Previous Episodes of Care	26
Associating a Follow-up Date with a Closed Episode of Care	26
Episodes of Care within Instruments/Assessments	27
IMPAIRMENTS TAB.....	30
Graphs on Impairments Tab	30
Body Mass Index (BMI).....	30
Conditions, Diagnoses, and Procedures	31
Assessment Entry Forms on Impairments Tab.....	31

MEDICAL COMPLICATIONS TAB	33
Graphs on Medical Complications Tab.....	33
Pneumonia and Respiratory Section.....	33
Influenza Section.....	34
Urinary Tract Infections Section	35
Pressure Ulcers Section.....	35
Pressure Ulcer Risk Subsection	36
Pressure Ulcer Scale for Healing (PUSH).....	36
Pressure Ulcer Report	37
Pressure Ulcer Finish Subsection.....	37
Pain Section.....	38
Short Form McGill Pain Questionnaire (SF-MPQ)	38
Pain Assessment & Treatment Report	38
ACTIVITIES TAB.....	39
Graphs on Activities Tab.....	39
Activities Tab Assessment Entry Forms, Scores, and Benchmarks.....	39
Functional Independence Measure (FIM).....	39
Functional Assessment Measure (FAM).....	40
MNFM Form.....	40
Kurtzke Expanded Disability Status Scale (EDSS)	40
Kurtzke Functional Systems Scale (FSS)	41
PARTICIPATION & SWLS TAB	42
Graphs on Participation & SWLS Tab	42
Attendant Care Section of Participation and SWLS Tab	43
Social Section of Participation and SWLS Tab.....	43
Assessment Entry Forms on Participation & SWLS Tab.....	44
CHART-SF Assessment Entry Form.....	44
Diener’s Satisfaction with Life Scale (SWLS) Assessment Entry Form	44
CHART-SF Subscales Section.....	44
Occupation and Education Section.....	45
ASSESSMENT ENTRY FORMS.....	47
Header of Assessments.....	47
Button Functions on Assessments.....	48
General Procedure for Creating Assessments	49
Editing Assessments.....	50
Blank Assessment Forms	51
Progress Notes.....	52
REPORTS TAB	54
Custom Reports	55

Impairments and Medical Complications Reports	55
Cumulative Reports.....	56
Patient Listing(s) Reports.....	56
Filtered Reports	57
Report Filters.....	60
ADMINISTRATION AND INFORMATION RESOURCE MANAGEMENT	64
Administration Tab	64
User Roles and Record Access	64
SCI Region List of Institutions	65
Import Patient Records	65
Activate or Inactivate a Patient’s Status.....	66
Information Resource Management (IRM) Page	70
Regional Attributes.....	70
Regional Institutions.....	71
Monitor System Activity.....	71
National/Regional Update.....	72
APPENDIX A: DEFINITIONS AND ACRONYMS	73
APPENDIX B: COPYRIGHT INFORMATION	76
APPENDIX C: INSTRUMENTS AND FORMS	78
American Spinal Injury Association (ASIA)	79
Alcohol Use Disorders Identification Test (AUDIT) Instrument.....	82
Body Mass Index (BMI) Instrument	84
CAGE	85
Center for Epidemiologic Studies Depression Scale (CES-D).....	86
Craig Handicap Assessment and Reporting Technique Short Form (CHART-SF).....	87
Check Your Health (CYH) and Secondary Conditions.....	90
Drug Abuse Screening Test (DAST).....	92
Duke Severity of Illness (DUSOI) Checklist	93
Duke Severity of Illness Analog (DUSOI-A) Scale.....	96
Functional Assessment Measure (FAM).....	97
Functional Independence Measure (FIM)	98
Kurtzke Expanded Disability Status Scale (EDSS).....	100
Kurtzke Functional Systems Scale (FSS).....	101
Medical Needs Function Modifiers (MNFM)	102
PRIME-MD® Depression Screening	103
Pressure Ulcer Scale for Healing (PUSH).....	104
Satisfaction with Life Scale (SWLS) (Diener’s).....	105

SF-8 Health Survey	106
Short Form McGill Pain Questionnaire (SF-MPQ).....	108
Registration Ancillary Data Entry Form	109
Patient Education Form.....	111
APPENDIX D: REPORTS.....	113
Influenza Diagnoses and Treatment Report	114
Influenza Immunizations Report	115
Pain Assessment and Treatment Report.....	116
Pneumonia and Respiratory Report.....	117
Pneumococcal Immunizations Report.....	118
Pressure Ulcer Report.....	119
Urinary Tract Infections Report	120
RAI-MDS Quality Indicators Report	121
RAI-MDS Resource Utilization Groups (RUGS) Report"	122
Cumulative Reports.....	123
Custom Reports	130
INDEX.....	133

Introduction

The Spinal Cord Injury and Disorders Outcomes (SCIDO) application is a system for compiling spinal cord injury and disorders information. The SCIDO application accesses several other Veterans Health Information Systems and Technology Architecture (VistA) programs that contain information regarding diagnoses, prescriptions, surgical procedures, laboratory tests, radiological exams, patient demographics, hospital admissions, and clinical visits. This access allows clinical staff to take advantage of the data supported by VistA. Information can be summarized at three levels: local medical center, SCI&D region, or national research access.

Recommended Users

The SCIDO application is designed for clinicians, administrators, and researchers who provide care to Veterans with spinal cord injury or disorders.

Related Manuals or Documents

SCIDO 3.0 Interim Regional J2EE Installation Guide

SCIDO 3.0 Deployment Guide

SCIDO 3.0 Interim Technical Manual/Security Guide

SCIDO 3.0 Interim VistA Installation Guide

SCIDO 3.0 Interim Release Notes

VistA Document Library

Online documentation for this product is available in the VistA Document Library (VDL) . Use the following internet address to access the VistA Document Library: <http://www.va.gov/vdl/>. Select the Spinal Cord Injury and Disorders Outcomes link to access the SCIDO documentation.

Section 508 Compliance

The Veterans Health Administration (VHA) fully supports Section 508 of The Rehabilitation Act and is committed to equal access for all users. Every effort has been made to ensure that the SCIDO application meets Section 508 compliance. The SCIDO application was assigned a status of Section 508 compliant on May 10, 2010.

VA Service Desk

REDACTED

Overview and Features

The SCIDO application has been organized using World Health Organization concepts. After a cover sheet summarizing the patient's status and a registration sheet, tabs address impairments, medical complications, activities, and participation. The reports tab and administration tab follow these health domain tabs.

Subject Tabs

The footer of each page contains seven tabs representing the pages of the application. Moving from one page to another is possible by simply selecting the tabs located at the bottom of each page. For example, if the user is on the Activities tab and wants to open the Impairments tab, the user selects the Impairments tab in the footer.



Subject Tabs

The SCIDO application can be navigated through the following tabs:

Cover Sheet – displays a summary of the patient's status. It displays recent diagnoses and CPT codes from the past five years. The Cover Sheet also displays information the user may have entered through three other tabs of the application. If the information has not been entered, these fields will be blank. The patient record opens to the Cover Sheet unless the Veteran has not been registered in the SCIDO application.

Registration Tab – used to register Veterans into the SCIDO application and to enter data, which allows staff access to valuable regional and local program data. This information is designed to simplify your job. Investing a small amount of time entering registration and other useful information will return valuable dividends when the information is needed in reports or displayed.

Impairments Tab – Impairments refer to any loss of psychological, physiological, or anatomical structure or function. Impairments affect organ systems, thought, or emotion. Information about impairments is provided on both the Impairments Tab and the Medical Complications Tab.

Medical Complications Tab – Medical Complications are impairments that are commonly associated with spinal cord injury; therefore, this tab focuses on respiratory complications, urinary tract infections, influenza, pressure ulcers, and pain. These secondary complications are common, costly, and can be disruptive to activities, participation, and satisfaction with life.

Activities Tab – activities are tasks and actions by an individual at the level of a person rather than the anatomic, physiological, or social levels. Activities have been associated traditionally with abilities, disabilities, or independence. This tab summarizes common activity limitation measures such as the FIM, FAM, and Kurtzke EDSS and FSS measures, which are used specifically for multiple sclerosis.

Participation & SWLS Tab – participation reflects the nature and extent of a person's involvement in life situations at a social or societal level and often pertains to participating in meaningful social roles. This tab summarizes participation information based on the CHART-SF and also includes Diener's Satisfaction with Life Scale (SWLS).

Reports Tab – reports reflect the benefits of accurately maintaining the SCIDO application for the Veterans you serve. Templated reports regarding impairments and medical complications, aggregate outcome reports, and patient listings are available for ready review. Filtered reports allow the selection of specific portions of the population for review before the reports are generated. For unique reports that affect your practice, you can learn how to use the Report Designer to generate custom reports for the population.

Administration Tab – provides the functionality to display user names and roles; SCI Regional definitions; activate or inactivate a patient status; activate or inactivate patient assessments; activate or inactivate Episodes of Care; import patient records from the national database; and add or delete SCI and Multiple Sclerosis (MS) mail groups.

Information Resource Management (IRM) tab – allows a person within the IRM/ISS/ITS user role to add or delete medical centers from SCI&D regions, modify regional attributes, perform a national or regional audit, and monitor system activity.

Tab Header

Each tab has a standard header , which contains information from the following sources:

- Veteran's Last Name, Veteran's First Name MI (VistA)
- Veteran's Social Security Number (VistA)
- Veteran's Date of Birth (VistA)

NOTE: Date of Birth does not display in SCIDO for Veteran employees

- Veteran's Computed Age (VistA)
- Highest Level of Education (Registration Tab)
- ASIA Highest Neurological Level (ASIA Form)
- Current Employment Status (Participation Tab)
- ASIA Impairment Scale (ASIA Form)
- Bladder Drainage Method (Medical Complications Tab)
- Next Annual Evaluation Due (Registration Tab)
- Stage of most severe Pressure Ulcer (PUSH form)

 Patient Search	Spinal Cord Injury and Disorders Outcomes				Logout
Name: SPINALCORD,SIXTEEN SSN : 000-00-0016	Date of Birth : 03/04/1933 (74 yrs.) Education: PR	Neuro. Level: C07 Employment: RT	ASIA: C Bladder Drainage: SC	Next AE Due: 05/09/2008 Pressure Ulcer: 3	

Tab Header

A *Patient Search* button is provided in the header. When the *Patient Search* button is selected, the Patient Lookup window allows the selection of a different patient. Refer to the [Patient Lookup](#) section of this document for more information.

A *Logout* button is provided in the header. When the *Logout* button is selected, the application logs the current user out of the application and returns to the main login page. Refer to the [Accessing the System](#) section of this document for more information.

Buttons Used on Tabs

The *Print*, *Reset*, *Submit*, and *Help* buttons are located at the bottom of most, but not all tabs. The Cover Sheet and Activities tabs have only the *Print* and *Help* buttons. In the case of these tabs, nothing needs to be submitted or reset since all fields are display-only.



Print Button

To print the current page, select the *Print* button.

Reset Button

Selecting the *Reset* button will return the previously saved values on the tab.

For assessments, the *Reset* button is similar to the Tab reset button. The *Reset* button will return previously saved values or the values present when the *Calculate* function was last used.

Submit Button

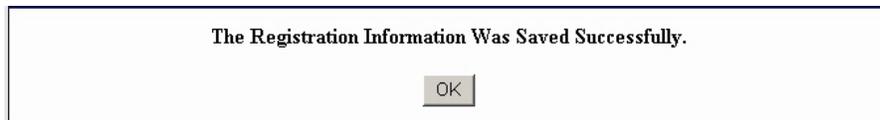
Select the *Submit* button to save and record the values entered in the tab fields.

If data is not entered in all required fields, a reminder will prompt the user to enter the required data. For example, on the Registration tab, if any of the required fields (Registration, SCI Network, and Date Changed) are not populated, the user will be alerted with a message, such as the following.



Select *OK* to return to the Registration page to complete the fields.

Once required fields are complete and the *Submit* button has been selected, a message will confirm the information was saved. The following is an example from the Registration Tab.



Select *OK* to return to the Registration Tab for viewing and navigation to other pages of the SCIDO application or for selecting a new patient.

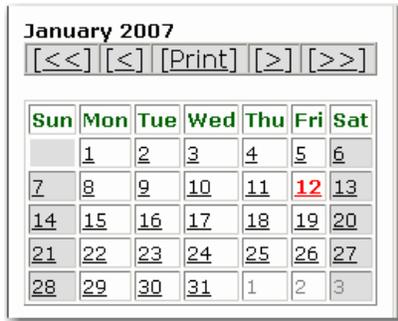
Help Button

To access SCIDO Online Help, select any *Help* button. The Online Help includes instructions, procedures, and other information to help you use the SCIDO application. By default, the Online Help provides information about the particular page from which it was launched. For example, pressing *Help* on the Registration Tab displays information about the Registration page and provides links to other related information, such as the Registration Additional Information section.

Calendar



Select the Calendar Icon located to the right of a date field to modify or add a date to a field. The calendar for the current month is displayed by default.

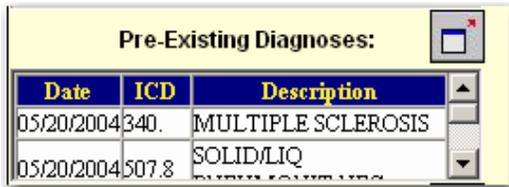


Select the << symbol to access the previous year.
 Select the < symbol to access the previous month.
 Select the *Print* button to print the calendar.
 Select the >> symbol to access the next year.
 Select the > symbol to access the next month.

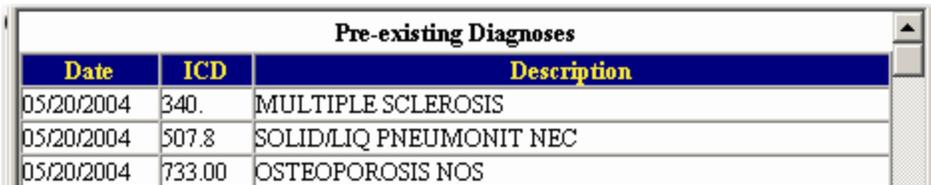
Window Expander Icon



Selecting the Window Expander Icon opens a separate window with a scrollbar. The Window Expander is useful when there is too much detailed information to be displayed in the space available on the screen. The SCIDO application often displays only the most recent value or values on the tab itself. For example, on the Impairments tab, the Pre-Existing Diagnoses field may have room to show just two diagnoses.



If the Window Expander Icon for the Pre-Existing Diagnoses is selected, a separate window is displayed showing all diagnoses. Use the scrollbar to view all pre-existing diagnoses.



History Fields

History fields show fields' historic values or a historic listing of completed assessments. History fields have a dropdown arrow that, when selected, displays the list of historic values for that field in descending order. For example, the Network History field on the Registration page has a dropdown that shows all historical values for the Registration and SCI Network fields.



For another example, on the Impairments Tab, next to the ASIA assessment entry button, is a field that shows the most recently completed ASIA Neurological Level, Impairment Scale, record date, and score type. Select the dropdown to view a listing of the neurological levels, impairment scales, record dates, and score types for all ASIA assessments You can view (and edit) individual assessments by selecting one of the assessment history lines.

Scores / Date	
ASIA	C07, C, 06/16/2006 UN

C07, C, 06/16/2006 UN
C04, D, 06/03/2006 UN
C05, E, 06/02/2006 ST
C06, D, 01/30/2006 FI

Instruments

The SCIDO application provides twenty instruments (assessment entry forms) for creating assessments for patients.

SCIDO Instruments

ASIA	The American Spinal Injury Association Standard Neurological Classification of Spinal Cord Injury (ASIA) instrument uses findings from the neurological examination to identify and classify different injuries and degrees of spinal cord damage.
AUDIT	The Alcohol Use Disorders Identification Test (AUDIT) instrument is derived from the World Health Organization's Alcohol Use Disorders Identification Test and provides questions about a person's alcohol use.
BMI	The Body Mass Index (BMI) form provides calculation of a Body Mass Index as a measure of body fat based on height and weight that applies to both adult men and women.
CAGE	Brief four-item alcohol disorder assessment instrument.
CES-D	The Center for Epidemiologic Studies - Depression Scale (CES-D) is a short, self-reporting scale intended for measuring current depressive symptoms in the general population.
CHART-SF	The Craig Handicap Assessment and Reporting Technique – Short Form (CHART-SF) was designed to provide a simple, objective measure of the degree to which impairments and disabilities result in limitations to participation in meaningful social roles.
CYH	The Check Your Health and Secondary Conditions Checklist (CYH) is designed to help identify people who are at risk for secondary conditions.
DAST	Drug Abuse Screening Test. The purpose of the DAST is to provide a brief, practical, but valid method for identifying individuals who are abusing psychoactive drugs and to yield a quantitative index score of the degree of problems related to drug use and misuse.
DUSOI	The Duke Severity of Illness (DUSOI) Checklist Scale is a generic assessment of the patient's comorbidities.
DUSOI-A	Duke Severity of Illness Analog is single-item generic assessment of the overall comorbidity experienced by a patient based on the clinician's judgment.
FAM	The Functional Assessment Measure is an activity measure used as an adjunct to the FIM to address the major functional areas less emphasized in the FIM, including cognitive, behavioral, communication, and community functioning measures.
FIM	The Functional Independence Measure (Guide for the Uniform Data Set for Medical Rehabilitation, 1996) is the most widely used activity or functional assessment measure in the rehabilitation community.
Kurtzke EDSS	Kurtzke Expanded Disability Status Scale (used for Multiple Sclerosis).
Kurtzke FSS	Kurtzke Functional Systems Scale Rating (used for Multiple Sclerosis).
MNFM	Medical Needs/Function Modifiers contains items from the Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) pertaining to swallowing status, clinical signs of dehydration, bladder frequency of accidents in the past seven days, and bowel frequency of accidents in the past seven days.

PRIME-MD	The Primary Care Evaluation of Mental Disorders (PRIME-MD) Depression Screening is a short instrument useful for detecting depression in primary care.
PUSH	The Pressure Ulcer Scale for Healing instrument is a quick, reliable tool to monitor change in pressure ulcer status over time.
SF-MPQ	McGill Pain Questionnaire (Short Form) measures a patient's subjective pain experience by using two dimensions of pain, sensory pain rating index (S-PRI) and affective pain rating index (A-PRI), and a total pain rating index (T-PRI).
SF-8	The SF-8 Health Survey is a generic multipurpose survey of health status.
SWLS	Diener's Satisfaction with Life Scale (SWLS) is a global measure of life satisfaction.

Refer to [Appendix C: Instruments and Forms](#) for a visual representation and functionality of each instrument.

Accessing the System

To launch the SCIDO application, double-click on the SCIDO icon located on the desktop or use your own method, such as typing in the URL in your browser. The Login window is displayed:

U.S. Government Computer System

U. S. government systems are intended to be used by authorized government network users for viewing and retrieving information only, except as otherwise explicitly authorized for official business and limited personal use in accordance with policy. Information from these systems resides on and transmits through computer systems and networks funded by the government. All access or use constitutes understanding and acceptance that there is no reasonable expectation of privacy in the use of Government networks or systems.

The data and documents on this system include Federal records that contain sensitive information protected by various Federal statutes, including the Privacy Act, 5 U.S.C. § 552a, and veterans' records confidentiality statutes such as 38 U.S.C. §§ 5701 and 7332. Access to the data and records is on a need-to-know basis only.

All access or use of this system constitutes user understanding and acceptance of these terms and constitutes unconditional consent to review and action including (but not limited to) monitoring, recording, copying, auditing, inspecting, investigating, restricting access, blocking, tracking, disclosing to authorized personnel, or any other

Log on for: Spinal Cord Injury and Disorders Outcomes(SCIDO)

Enter access code: [.....]

Enter verify code: [.....]

Sort by Station Number * Sort by Station Name *

[Refresh]

Institution: [CHEYENNE VAMC (442) *]

[Login]

* Persistent Cookie Used ([more information](#))

Logging In

To Login, enter an access code, a verify code, and select your institution. Select the *Login* button. This opens the Patient Lookup window.

Patient Lookup

The Patient Lookup window is opened after successful login. It may also be accessed by selecting the *Patient Search* button located on the page header. The Patient Lookup screen appears as follows:

Patient Lookup Help

Limit Patient Selection By: [Inpt. Provider] [Ward] [Clnic] [Specialty] [Clear Search]

» Select Patient: [SPINALCORD.] [Search]

The Patient Lookup window will default to the user's medical center. Enter a patient's name or at least two characters of their last name in the Select Patient field and select the *Search* button. The results of the search are displayed as a list with each matching Patient Name, Social Security Number (SSN), Date of Birth (DOB), Gender, Patient Type, and Eligibility.

NOTE: Date of Birth does not display in Patient Lookup for Veteran employees

NOTE: Patient picture functionality is unavailable at this time.

Patient Lookup
[Help](#)

Limit Patient Selection By: Inpt. Provider Ward Clinic Specialty Clear Search

➤ Select Patient: Search

Name	SSN	DOB	Gender	Patient Type	Eligibility
SPINALCORD,EIGHT	000000008	09/14/1930 (76)	M	NSC VETERAN	NON-SERVICE CONNECTED
SPINALCORD,EIGHTEEN	000000018	08/24/1947 (59)	M	SC VETERAN	SC, 50% TO 100%
SPINALCORD,ELEVEN	000000011	09/05/1933 (73)	M	NSC VETERAN	NON-SERVICE CONNECTED
SPINALCORD,FIFTEEN	000000115	02/27/1953 (54)	M	SC VETERAN	SC, 50% TO 100%
SPINALCORD,FIVE	000000005	06/14/1928 (78)	M	SC VETERAN	SC, 50% TO 100%
SPINALCORD,FOUR	Sensitive	Sensitive	F	NON-VETERAN (OTHER)	OTHER FEDERAL AGENCY
SPINALCORD,FOURTEEN	000000014	10/23/1946 (60)	M	SC VETERAN	SC, 50% TO 100%
SPINALCORD,NINE	000000009	08/24/1933 (73)	M	SC VETERAN	SC, 50% TO 100%
SPINALCORD,NINETEEN	000000019	11/17/1954 (52)	M	SC VETERAN	SC, 50% TO 100%
SPINALCORD,ONE	000000001	09/22/1927 (79)	M	SC VETERAN	SC, LESS THAN 50%

First Previous You are viewing results 1 - 10 of 31 Next Last

Click on the patient's name, and a Patient Lookup Status Notification window is displayed:

Patient Lookup Status Notification

Name: SPINALCORD,SIXTEEN SSN: 000000016 DOB: 03/04/1933 (72)

Enrollment Priority: GROUP 5
Category: ENROLLED

Continue enter
Cancel esc

Review the Patient Lookup Status Notification. Select the *Cancel* button to return to the Patient Lookup screen. Select the *Continue* button to continue to the patient's SCIDO records. Several Patient Lookup Status Notifications may be displayed. Only one example of a Patient Lookup Status notification has been represented here. Continue reviewing the notifications and selecting the *Continue* button until the Spinal Cord Injury and Disorders (SCIDO) system opens to either the Cover Sheet (if the patient is already registered) or the Registration page.

Cover Sheet Tab

or

Registration Tab

Patient Lookup: Limit Patient Selection

The following criteria may be used to limit the search for patient data:

- Inpatient Provider
- Clinic
- Ward
- Specialty

For example, to limit by specialty, select the *Specialty* button. From the list of available specialties, use the right > and left < buttons to move the specialty in or out of the selected box on the right. To select more than one specialty at one time, hold down the Ctrl Key and highlight all desired specialties. To select a range of specialties, select the first specialty, hold down the Shift Key, make the final specialty selection, and then select the *Search* button.

Name	SSN	DOB	Gender	Patient Type	Eligibility
SPINALCORD,ELEVEN	000000011	09/05/1933 (73)	M	NSC VETERAN	NON-SERVICE CONNECTED
SPINALCORD,SIX	000000006	01/01/1942 (65)	M	SC VETERAN	SC, 50% TO 100%

From the list of matching results, click on the patient's name. One or more Patient Lookup Status Notification windows will display. Continue until the SCIDO patient record displays.

Cover Sheet Tab

The Cover Sheet displays recent diagnoses and CPT codes from the past five years. The summary sheet also displays information the user may have entered through three other SCIDO tabs ([Medical Complications](#), [Participation](#), and [Activities](#)). If the information has not been entered, these fields will be blank. For the Medical Complications section, Present Pain Index (PPI) scores with a value of “99=Unable to Respond” are excluded from graphical display on the Cover Sheet.

The data presented on the Cover Sheet may not be selected or modified. The Cover Sheet is used only for viewing, printing, selecting Help, and navigation to other pages within the application.

If the patient is already registered in the application, the Cover Sheet opens by default. If a patient is not registered in the application, the Registration page opens. For registration information, refer to the section titled [Registration Tab](#).

Registration Tab

Registering a Patient

If a patient is not yet registered in the application, the Registration page will open first, rather than the Cover Sheet. Three fields in the Registration Tab must be completed to submit registration information:

- Registration (Status)
- SCI Network?
- Date Changed

These fields are marked with a red asterisk as a reminder of their required status. A patient is considered registered when information has been submitted for these required fields.

Spinal Cord Injury and Disorders Outcomes

Name: SPINAL_CORD_SIXTEEN Date of Birth: 03/04/1933 (74 yrs.) Neuro. Level: C07 ASIA: C Next AE Due: 05/09/2008
 SSN: 000-00-0016 Education: PR Employment: RT Bladder Drainage: SC Pressure Ulcer: 3

Registration and Network Status

- * Registration:
- * SCI Network? Yes No
- * Date Changed: Network History:

ASIA Information

Highest Neurological Level: C07 Impairment Scale: C

Primary Care Information

Primary Care VAMC: Provider:

Etiology Information

Trauma Non-Trauma NMS = Multiple Sclerosis MS Subtype:

Describe Other Etiology:

Date of Onset: History:

Annual Evaluation Information

Offered: Received: Veteran declines further Annual Evaluation

Next Due: AE VAMC:

Additional Information

Highest Level of Education:

Occupation at Time of Injury:

Service-Connected for SCI: Yes No

First Seen in VA for SCI:

Amount VA Is Used:

SCI&D Outcomes Coordinator:

Historic SCI&D Outcomes Coordinators:

Display Information

Metro/Micro/Rural:

Veteran's Home Address:

Registration Date: 06/10/2005

Date of Last Review: 05/23/2007

Last Updated By: User Gui Sciclinician

VA SCI Status: 3=Para-NonTrauma

Date of Death:

Enrollment Priority: GROUP 5

Medical Centers Visited:

Cover Sheet Registration Impairments Medical Complications Activities Participation & SWLS Reports

The Registration page is organized in three columns: the main Registration Information in the middle, Registration Additional Information on the left, and Registration Display Information on the right.

Registration Tab Information

The center salmon-colored column of the Registration tab records information recommended in VHA Handbook 1176.1 “Spinal Cord Injury & Disorders System of Care Procedures” as a basic data set. The center Registration Information column has the following five sections:

- [SCIDO Registration and Network Status](#)
- [ASIA Information](#)
- [Primary Care Information](#)
- [Etiology Information](#)
- [Annual Evaluation Information](#)

Registration and Network Status Section

The first section of the middle column of the Registration Tab is the Registration and Network Status section, which pertains to information about the patient's registration status and SCIDO network status.

Registration (Status) Field

To enter a patient's registration status, select one of the following values from the Registration Status dropdown:

- NS = Not SCD – Designates a person who does not have a true spinal cord injury or disorder but might have paralysis due to another cause, such as stroke, peripheral nerve disorder, or mental health disorder.
- SN = SCD – Not Currently Served – Designates a person with a spinal cord injury or disorder who is not being seen at a VHA facility. Examples include Veterans who have relocated, who have not returned for follow-up appointments, or who have not had an appointment in two to four years.
- SS = SCD – Currently Served
- X = Expired

SCI Network? Field

To record the patient's SCIDO Network status, select either the *Yes* or *No* radio button.

Selecting *Yes* indicates that the Veteran receives clinical and follow-up services, including annual evaluations, within the SCI&D system of care. The Veteran should either be offered or referred for annual evaluations at the SCI Center or approved SCI Outpatient Support Clinic if the SCI Network is marked *Yes*.

Selecting *No* indicates that the patient is followed primarily by Neurology Service, Rehabilitation Care Service, or another professional service.

Date Changed Field

Record the date or use the Calendar icon to designate the date the patient entered or left the SCI Network. When the SCI Network field? is changed to or from *Yes* or *No*, the date should be changed in the Date Changed field.

Network History Field

The Network History field displays information about when a patient entered or left the SCI Network. This field displays the historic values from two fields: *Yes* or *No* from the SCI Network? field and the corresponding date in the Date Changed field.

ASIA Information Section

The ASIA Information section pertains to the patient's ASIA assessment values. If these fields are blank, an ASIA assessment has not been completed yet for the patient. A health care provider can complete an ASIA assessment form within the application.

ASIA Information	
Highest Neurological Level: C07	Impairment Scale: C

Highest Neurological Level Field

The ASIA Highest Neurological Level field is a display-only field that is populated from the most recently completed ASIA Non-Goal assessment. This value is the most cephalic (closest to the head) of the values in the Neurological Levels section (Sensory Right, Motor Right, Sensory Left, Motor Left). See the Instruments section for detailed information on the ASIA instrument. Neurological Level values include the following:

C01 = Cervical 01	T08 = Thoracic 08
C02 = Cervical 02	T09 = Thoracic 09
C03 = Cervical 03	T10 = Thoracic 10
C04 = Cervical 04	T11 = Thoracic 11
C05 = Cervical 05	T12 = Thoracic 12
C06 = Cervical 06	L01 = Lumbar 01
C07 = Cervical 07	L02 = Lumbar 02
C08 = Cervical 08	L03 = Lumbar 03
T01 = Thoracic 01	L04 = Lumbar 04
T02 = Thoracic 02	L05 = Lumbar 05
T03 = Thoracic 03	S01 = Sacral 01
T04 = Thoracic 04	S02 = Sacral 02
T05 = Thoracic 05	S03 = Sacral 03
T06 = Thoracic 06	S04 = Sacral 04
T07 = Thoracic 07	S05 = Sacral 05
UNK = Unknown	

NOTE: A new ASIA assessment needs to be completed to change the displayed value.

Impairment Scale Field

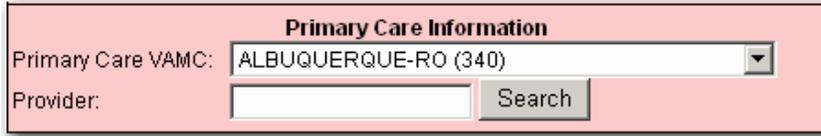
The ASIA Impairment Scale field is a display-only field that is populated from the most recently completed ASIA Non-Goal assessment. (See the Instruments section for detailed information on the ASIA assessment.) Impairment Scale values that can be displayed include the following:

A = Complete: No sensory or motor function is preserved in the sacral segments S4-S5
B = Incomplete: Sensory but not motor function is preserved below the neurological level and includes the sacral segments S4-S5
C = Incomplete: Motor function is preserved below the neurological level, and more than half of key muscles below the neurological level have a muscle grade less than 3 (Grades 0-2)
D = Incomplete: Motor function is preserved below the neurological level, and at least half of key muscles below the neurological level have a muscle grade greater than or equal to 3.
E = Normal: Sensory and motor function are normal.
UNK = Unknown

NOTE: A new ASIA assessment needs to be completed to change the value of this display.

Primary Care Information Section

The Primary Care Information section pertains to information about the patient's primary care physician and medical center.



Primary Care VA Medical Center Field

In the Primary Care VAMC field, select the VA Medical Center where the patient receives most of their primary care. To select the VAMC from the dropdown, type the first letter of the medical center name, and the list will start from that alphabetical section.

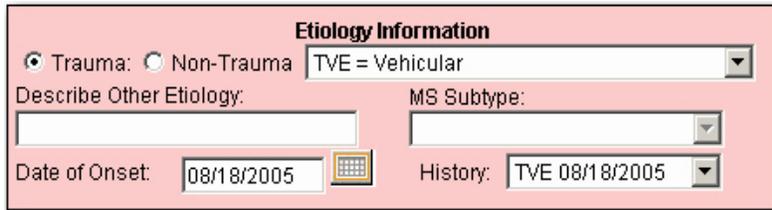
NOTE: SCI Center staff should enter the VA Medical Center where the patient receives primary care locally. This ensures the local VAMC may receive e-mail notifications of patient admissions, discharges, and transfers.

Primary Care Provider Field

Select the *Search* button and enter part of the provider's last name. The application will display matching names from which the primary care provider can be selected.

Etiology Information Section

The fourth section of the middle column of the Registration Tab pertains to information about the patient's etiology or etiologies.



(Etiology) Trauma or Non-Trauma

Select either Trauma (Traumatic) or Non-Trauma (Non-Traumatic) to describe the overall category of the cause of the Veteran's spinal cord injury or disorder.

(Etiology) Field

In the Etiology field next to the Trauma and Non-Trauma buttons, select a category from the dropdown list that best describes the cause of the patient’s spinal cord injury or disorder. If the Traumatic radio button was selected, one of the following six traumatic causes may be selected:

- TFA = Fall
- TSA = Sports Activity
- TVE = Vehicular
- TVI = Violence
- TOT = Other (Traumatic)
- TUN = Unknown (Traumatic)

If the Non-Trauma was selected, one of the following non-traumatic causes may be selected:

- NIA = Infection or Abscess
- NMN = Motor Neuron Disease
- NMS = Multiple Sclerosis
- NPM = Poliomyelitis
- NSY = Syringomyelia
- NTU = Tumor
- NOT = Other (Non-Traumatic)
- NTV = Vascular
- NUN = Unknown (Non-Traumatic)
- NAD = Arthritic Disease or Cervical Stenosis

NOTE: If either “TOT Other (Traumatic)” or “NOT = Other (Non-Traumatic)” is selected, enter a description of the cause of the Veteran’s spinal cord injury or disorder in the “Describe Other Etiology” field (See [Describe Other Etiology Field](#) below).

Date of Onset Field

In the Date of Onset field, manually enter a date or select the Calendar icon to designate the date when the spinal cord injury occurred or the spinal cord disorder began.

Describe Other Etiology Field

The Describe Other Etiology field is a text-entry field for entering etiology descriptions that are not listed in the Etiology dropdown. A description of up to 35 characters in length may be entered to describe the cause of the patient’s spinal cord injury or disorder.

NOTE: The Describe Other Etiology field is not available for text entry unless either “TOT = Other (Traumatic)” or “NOT = Other (Non-Traumatic)” has been selected in the Etiology field.

MS Subtype Field

Select the MS Subtype that best describes the patient’s multiple sclerosis diagnosis:

- UN = Unknown
- RR = Relapsing-Remitting
- PP = Primary Progressive
- SP = Secondary Progressive
- PR = Progressive Relapsing

NOTE: The MS Subtype field is available when there has been an etiology of multiple sclerosis. If the Etiology field has once had a value of “NMS = Multiple Sclerosis”, then the user may enter a value in the MS Subtype field.

(Etiology) History Field

The Etiology History field is a dropdown that displays historic etiology values and dates of onset for the patient.

Annual Evaluation Information Section

The fifth section of the middle column of the Registration Tab is the Annual Evaluation Information section, which pertains to information about the patient's annual evaluations (AE).

Annual Evaluation Information

Offered: 11/04/2005 

Received: 12/12/2006  Veteran declines further Annual Evaluation

Next Due: 12/12/2007 

AE VAMC: 

(Annual Evaluation) Offered Field

In the Annual Evaluation Offered field, manually enter a date or select the Calendar icon to designate the date when the patient was offered the opportunity to schedule an annual evaluation.

NOTE: This is the date when the SCI coordinator offered the evaluation, not the actual date of the anticipated annual evaluation.

Veteran declines further Annual Evaluation Field

If the patient declines future annual evaluations, select the “Veteran Declines Future Annual Evaluation” field. A checkmark will indicate that the patient does not want to be reminded about future annual evaluations. To uncheck this field, select this field again.

(Annual Evaluation) Received Field

In the Annual Evaluation Received field, manually enter a date or select the Calendar icon to designate the date when the patient actually received an annual evaluation.

(Annual Evaluation) Next Due Field

The Next Due field automatically displays a date one year from the date listed in the Annual Evaluation Received field. This date may be changed manually or by selecting the Calendar icon.

(Annual Evaluation) AE VAMC Field

Select the VA Medical Center where the patient receives an annual evaluation.

Registration Additional Information

The left column of the Registration page displays additional patient information. The lower gray area of the column provides buttons that open the [Episodes of Care Management](#) page and the [Patient Education](#) and [Ancillary Data Entry forms](#).

Additional Information

Highest Level of Education:
[SC = Some College, Technical School, AA, or AS]

Occupation at Time of Injury:
[TR = Transportation]

Service-Connected for SCI: Yes No

First Seen in VA for SCI: []

Amount VA Is Used:
[VM = Mostly VA/Some Non-VA]

SCI&D Outcomes Coordinator:
[] [Search]

Historic SCI&D Outcomes Coordinators:
[]

[Episode of Care]
[Patient Education]
[Ancillary Data Entry]

Highest Level of Education Field

In the Highest Level of Education field, select from the dropdown one of the following values that best describes the patient's education level:

- LH = Less than High School Graduate
- HS = High School Graduate or GED
- SC = Some College, Technical School, AA, or AS
- CG = College Graduate
- PR = Graduate or Professional School

Occupation at Time of Injury Field

In the Occupation at Time of Injury field, select from the dropdown one of the following values that best describes the patient's occupation at the time of spinal cord injury or onset:

- PR = Professional and technical
- EX = Executive
- SL = Sales
- AD = Administrative support
- PP = Precision Production
- MO = Machine Operators
- TR = Transportation
- HA = Handlers
- SV = Service

Refer to the Department of Labor's Dictionary of Occupational Titles for a detailed description of these categories.

NOTE: The patient's current occupation is entered in the CHART-SF instrument and can be viewed on the [Participation & SWLS page](#).

Service-Connected for SCI Field

To indicate if the patient's spinal cord injury or disorder was incurred in or aggravated by military service, select either the *Yes* or *No* radio button.

First Seen in VA for SCI Field

The First Seen in VA for SCI field is used to designate the date when the patient was first treated at a VA medical center for spinal cord injury or disorder. Manually enter the date or select the Calendar icon.

Amount VA is Used Field

To indicate how much care the patient receives at VA and/or non-VA facilities, select from the dropdown one of the following values:

- VA = VA Only
- VM = Mostly VA/Some Non-VA
- HF = Half VA/Half Non-VA
- NM = Some VA/Mostly Non-VA
- NN = Non-VA Only
- NH = Did not see doctor/nurse last 5 years

SCI&D Outcomes Coordinator Field

Select the name of the SCIDO Outcomes Coordinator responsible for maintaining current patient information. The SCI Coordinator at non-SCI Center facilities typically has this responsibility.

Select the *Search* button and enter part of the SCIDO coordinator's last name. The system will display matching names from which you can select the coordinator.

Historic SCI&D Outcomes Coordinators Field

The Historic SCI&D Outcomes Coordinators field displays a list of previous SCIDO Coordinators. When the SCI&D Outcomes Coordinator field is updated, the previous coordinator's name is added to this history field.

Episode of Care Button

The Episodes of Care Management page is accessed from the Registration tab. For more information, refer to the [Episode of Care Management](#) section.

Ancillary Data Entry Button and Patient Education Button

The following forms are provided in the application and may be accessed from the Registration Tab:

- Ancillary Data Entry
- Patient Education

The Ancillary Data Entry Form is used to record sources of care, referral sources, bowel care information, and remarks. The form is described in Appendix C: Instruments and Forms in the section titled [Registration Ancillary Data Entry Form](#).

The Patient Education form is used to record the dates the patient is given educational materials on sixteen health-related topics. For a description of the form, refer to [Patient Education Form](#) in [Appendix C: Instruments and Forms](#).

Registration Display Information

The right column of the Registration page is populated from other applications. The information, with the exception of Date of Death, is display-only and not editable.

Display Information

Metro/Micro/Rural:

Veteran's Home Address:

1 Street Address

City, ST 00011

Registration Date: 06/10/2005

Date of Last Review: 05/29/2007

Last Updated By: User Gui Sciclinician

VA SCI Status: X=Not Applicable

Date of Death: 

Enrollment Priority:

Medical Centers Visited:

EASTERN COLORADO HCS 08/07/2

Print Reset Submit Help

Metro/Micro/Rural Field

The Metro/Micro/Rural field displays the classification of the patient's residence:

- MT = Metropolitan areas have more than 50,000 residents
 - MC = Micropolitan areas have 10,000 to 49,999 residents.
 - RL = Rural areas have less than 10,000 residents
- The field may also be blank

Veteran's Home Address Field

This field displays the Veteran's home address.

Registration Date Field

This field displays the date that the Veteran was first registered into the SCIDO application.

Date of Last Review Field

This field displays the most recent date that the Veteran's SCIDO information was accessed or reviewed.

Last Updated By Field

This field displays the name of the VA staff member who last updated or changed the patient's SCIDO information. The field may also display "Nightly Demographic Update" if the SCIDO system was updated during the nightly demographic batch run. The demographic update batch process looks for demographic changes in Vista and updates the following SCIDO cache data base items:

- Address Line 1 (home_address1)
- Address Line 2 (home_address2)
- City (city)
- State (state)
- Zip Code (zip)
- Residence Phone #
- Date of Death
- Enrollment Priority
- Ethnicity
- Marital Status
- Race
- VA SCI Status

VA SCI Status Field

This field displays the Veteran's self-reported SCI Status at the time of registration for VA healthcare. The displayed values include the following:

- 1 = Paraplegia-Traumatic
- 2 = Quadriplegia-Traumatic
- 3 = Paraplegia-Nontraumatic
- 4 = Quadriplegia-Nontraumatic
- X = Not Applicable

Date of Death Field

If the patient has died, this field displays the date of death recorded in the patient treatment file or Common Services. If the information is not accurate or has not been recorded, a SCI Coordinator may enter the date or select the date from the Calendar icon. Changing the date of death in the SCIDO application will not change the Date of Death in other VistA applications.

Enrollment Priority Field

This field displays the patient's enrollment priority as a value from 1 to 8.

NOTE: Patients with spinal cord injury diagnoses may be reclassified as catastrophically disabled (priority 4) if they have enrollment priorities of 5, 6, 7, or 8.

Medical Centers Visited Field

A dropdown list of VA Medical Centers at which the patient has received care is displayed. The most recent care location is displayed at the top of the list.

Episodes of Care

An Episode of Care can be described as health care services provided during a certain period of time, focused on a particular goal. In the SCIDO application, assessments within an episode of care will have the same care type and care start date. Episodes provide a useful basis for analyzing quality of care and utilization patterns.

In the application, outcomes information is related to a care type for every assessment. The following three care types require episode of care management: Inpatient Rehabilitation, Outpatient Rehabilitation, and Continuum of Care – Inpatient. Other care types do not use episode of care management.

The rules for entering assessments within an episode of care are described in the section titled [Episodes of Care within Instruments/Assessments](#).

Episode of Care Management

Episodes of care are managed using the Episodes of Care Management Page, where the user may create a new episode of care, close an episode of care, and associate a follow-up date with a closed episode of care. The user may review current (open) and previous (closed) episodes of care for a specified patient, including a list of assessment record dates, score types, and assessment types.

The Episodes of Care Management page is accessed from the Registration Tab. Select the button labeled *Episode of Care*, and the Episodes of Care Management window is displayed.

Spinal Cord Injury and Disorders Outcomes

Patient Search | Name: SPINALCORD,TWENTY-SEVEN | Date of Birth: 12/14/1945 (61 yrs.) | Neuro. Level: T02 | ASIA: D | Next AE Due: 06/13/2006 | Logout
 SSN: 000-00-0027 | Education: LH | Employment: UU | Bladder Drainage: | Pressure Ulcer: 2

Episodes of Care Management

Open Episode of Care | **Previous Episodes of Care**
 Create Episode of Care | Add Follow-up Date
 Close Episode of Care

Care Type: Inpatient Rehabilitation		
Record Date	Score Type	Instrument
02/04/2006	Start	SF-8
02/04/2006	Start	DUSOI
02/04/2006	Start	CES-D
02/03/2006	Start	AUDIT
02/02/2006	Start	ASIA
02/02/2006	Finish	ASIA
02/02/2006	Start	CAGE
02/02/2006	Start	CYH
02/02/2006	Start	FIM
02/02/2006	Start	SF-MPQ

Care Type:	Start Date	Closed Date	Follow-up Date
Continuum of Care - Inpatient	05/11/2005	08/01/2005	
Outpatient Rehabilitation	08/03/2004	10/10/2004	11/10/2004
Inpatient Rehabilitation	03/02/2004	04/10/2004	05/01/2004

Care Type: _____
 Record Date | Score Type | Instrument

Print | Help

Cover Sheet | Registration | Impairments | Medical Complications | Activities | Participation & SWLS | Reports

Current Open Episode of Care

If a current open episode of care exists, the information will be displayed on the left side of the Episodes of Care Management page. The Episode of Care (EOC) care type and start date are displayed, and completed assessments are listed by record date and score type for the open episode of care. Only one episode of care may be open at one time for a specific patient. When an episode of care is open, the *Create Episode of Care* button is not selectable.

Open Episode of Care

Care Type: Continuum of Care - Inpatient
EOC Start Date: 09/01/2006

Record Date	Score Type	Instrument
10/10/2006	Finish	SF-8
10/01/2006	Finish	DUSOI-A
10/01/2006	Finish	ASIA
09/20/2006	Interim	DUSOI-A
09/15/2006	Start	DUSOI-A
09/01/2006	Start	ASIA
09/01/2006	Goal	BMI
09/01/2006	Start	CYH
09/01/2006	Start	SF-8
09/01/2006	Start	BMI

Create a New Episode of Care

When no episode of care is open, the *Create Episode of Care* button is selectable.



Select the *Create Episode of Care* button to create a new episode of care, and the New Episode of Care form is displayed.

Spinal Cord Injury and Disorders Outcomes

Name: SPINALCORD,TWENTY-NINE Date of Birth : 06/06/1966 (39 yrs.) Neuro. Level: ASIA: Next AE Due: 06/12/2006

SSN : 000-00-0029 Education: Employment: NOT EMPLOYED Bladder Drainage: Pressure Ulcer:

New Episode of Care

Care Type:

EOC Start Date:

For the new episode of care, select one care type from the following choices:

- Inpatient Rehabilitation
- Outpatient Rehabilitation
- Continuum of Care - Inpatient

Provide the Episode of Care (EoC) Start Date for the episode of care by either manually entering the date or selecting the date from the calendar icon. The EoC Start date may be any time up to, and including, the current date. A future date may not be used. It is important to note that the EoC start date is not necessarily related to admission date.

When the *Submit* button is selected, the application closes the Open New Episode of Care form and returns to the Episodes of Care Management page. The Open Episode of Care section will show the care type and EoC start date for the new episode of care. Assessments may be added to the open episode of care until it is closed.

For each assessment type (for example, ASIA assessments) within an Episode of Care, only one:

- Start score type per instrument is allowed.
- Goal score type per instrument is allowed.
- Finish score type per instrument is allowed.

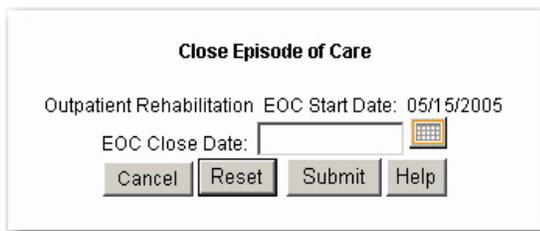
For a closed episode of care, only one Follow-up score type per instrument is allowed.

Closing an Episode of Care

An Episode of Care should be closed when the treatment has been completed or finished. Do not wait until a follow-up evaluation to close an Episode of Care. It is important to note that the EoC close date is not necessarily related to a discharge date.

NOTE: the EOC closed date is stored in SCIDO cache table EPISODE_OF_CARE, column CLOSED_DATE. The cache column CARE_END_DATE is used for migrated data. One day is subtracted from the migrated CARE_END_DATE to obtain the CLOSED_DATE for migrated data.

After an episode of care is closed, assessments may no longer be added, with the exception of those assessments with a score type of Follow-up. Please review the assessments before closing an Episode of Care to ensure that none have been overlooked or omitted. To close an episode of care from the Episodes of Care Management page, select the *Close Episode of Care* button.



The application displays the Close Episode of Care window with the care type and EoC Start Date for the current open episode of care.

Enter the Episode of Care (EoC) Close Date, either by manually entering the date or by selecting it from the calendar icon. The EoC Close Date is the date the episode of care was closed by the Clinician. It must be later than the EoC start date and later than or the same as the most recent record date of any assessment belonging to the episode of care. The EoC Close date may be before or the same as the current date. Future dates may not be used.

After entering the Close Date, select the *Submit* button to close the episode of care. The application will return to the Episodes of Care Management page and re-display the recently closed episode of care summary in the display area entitled Previous Episodes of Care.

Previous Episodes of Care

The right side of the Episodes of Care Management page displays information about Previous (Closed) Episodes of Care. The Care Type, Start Date, Closed Date, and Follow-up Date are displayed for each episode of care. Highlight an episode of care line, and a list of assessments in that selected episode are displayed by record date, score type, and instrument name in the section below. In the section below, double-click on an assessment record date to view and edit that assessment.

Previous Episodes of Care

Care Type:	Start Date	Closed Date	Follow-up Date
Continuum of Care - Inpatient	05/11/2005	08/01/2005	
Outpatient Rehabilitation	08/03/2004	10/10/2004	11/10/2004
Inpatient Rehabilitation	03/02/2004	04/10/2004	05/01/2004

Care Type: Continuum of Care - Inpatient

Record Date	Score Type	Instrument
07/01/2005	Finish	CYH
05/13/2005	Start	DUSOI
05/11/2005	Start	ASIA
05/11/2005	Start	CYH

Associating a Follow-up Date with a Closed Episode of Care

To add a Follow-up Date to a closed episode of care, select the appropriate episode of care in the Previous Episodes of Care section. Select the *Add Follow-up Date* button, and the Add Follow-up Date form is displayed:

Add Follow-up Date

Continuum of Care - Inpatient EOC Start Date: 05/01/2007 Close Date: 05/06/2007

Follow-up Date:

In the Add Follow-up Date form for the selected episode of care, enter the follow-up date, either manually or by selecting it from a calendar. The EoC Follow-up Date is the approximate date the Clinician conducted follow-up assessments for the chosen episode of care. The Follow-up date may be before or on the current date and must be at least one day later than the EoC close date. Select the *Submit* button to assign the follow-up date to the closed episode of care.

Once an assessment with a score type of Follow-up has been added to an episode of care, the EoC Follow-up Date may not be changed.

NOTE: Use the EoC follow-up date for all follow-up information entered through the assessment forms. This one date will be used to identify all related follow-up data, even if follow-up assessments were actually conducted on several different dates.

Episodes of Care within Instruments/Assessments

In the SCIDO application, assessments within an episode of care will have the same care type and care start date. It is suggested, but not required, that the ASIA assessment data be entered before other assessments. The application will remind the user to enter an ASIA assessment before all others.

The header of each assessment form has four fields that are important to episodes of care: Record Date, Care Type, Care Start Date, and Score Type.

The screenshot shows a form titled "Header of Instrument" with the following fields:

Name:	SPINALCORD,FOURTEEN	* Record Date:	09/01/2005
Division:	442	Care Start Date:	
* Care Type:		* Score Type:	
Score:	0		

Header of Instrument

Record Date Field

Enter the record date, the date the assessment was conducted, manually or by using the calendar to select the date.

Care Type Field

There are many different care types available, but episode of care management is used only if the care type is one of the following types:

- Inpatient Rehabilitation
- Outpatient Rehabilitation
- Continuum of Care - Inpatient

For any given patient, only one episode of care may be open at a time. If an episode of care is open when a new assessment is created, the care type for the current episode of care defaults into this field.

Care Start Date Field

If an episode of care is open, the application will display the care start date for that episode of care. If no episode of care is open, the application will display the Care Start Date field after an EoC care type value is entered. This field will have no value if the care type is not an EoC care type.

Score Type Field

Within an episode of care for each instrument type, the user may create only one assessment with a score type of Start, Goal, Finish, or Follow-up. For example, an episode of care may have only one ASIA assessment with a score type of Start. There may be more than one assessment with a score type of Interim. The score type of Unknown is not used with episodes of care. For example, the Unknown score type may be used with assessments with a care type of Annual Evaluation.

The following score types are used with episodes of care:

- Start = ST A score type of "Start" is used to identify the beginning of a treatment or rehabilitation episode of care. It rarely is the same date that the patient is admitted to the medical center. For example, a patient with a new onset of spinal cord injury may receive days of care to achieve medical or surgical stability before

Goal = GL	beginning rehabilitation; therefore, a rehabilitation episode of care begins on the day when the patient is participating in active rehabilitation but not before. A “Goal” score type is used to identify goals that are realistically expected to be achieved on a particular assessment at the close of an episode of care. The goal scores are usually determined by the health care or rehabilitation team including and in conjunction with the patient. Clinical practice guidelines and research articles are sometimes useful in establishing goals.
Interim = IN	“Interim” score types are used to track progress in increments between the start and finish of treatment services. Only “Interim” score types can be used multiple times for one instrument within an episode of care.
Finish = FI	A “Finish” score type is used to identify status at the end of a treatment or rehabilitation episode of care. It is rarely the same date that the patient is discharged from the medical center. For example, a patient may complete treatment for a certain condition but need to wait for the delivery of supplies and services to their home before they are discharged from the medical center. An episode of care should be closed when the particular type of treatment has been completed or finished. Do not wait until follow-up evaluation to close an episode of care.
Follow-up = FO	A “Follow-up” score type is used to identify if the patient’s status has been maintained at some time following completion of treatment or rehabilitation. For inpatient rehabilitation, it is customary to follow-up with patients three months after “Finish,” but other follow-up intervals may be used. There can only be one “Follow-up” date. This one date will be used to identify all related follow-up data even if follow-up assessments were actually conducted on several different dates. Follow-up information is an indication of treatment durability regarding whether treatment gains have been maintained after finishing active treatment or rehabilitation.
Unknown = UN	An “Unknown” score type should be used when a sequencing of score types is not indicated or when none of the previous score types are applicable. For example, a care type of Annual Evaluation (non-episode of care) would be likely to have all assessments associated with “Unknown” score types.

Adding Follow-up Assessments

Assessments with a score type of Follow-up may be added to closed episodes of care for which a follow-up date has been associated. The EoC Follow-up Date is the approximate date the Clinician conducted follow-up assessments for the chosen episode of care. This one date will be used to identify all related follow-up data, even if follow-up assessments were actually conducted on several different dates.

The follow-up date is entered on the Episodes of Care Management page for all follow-up information. Assessments with a score type of Follow-up cannot be added to that episode of care, until a Follow-up Date is assigned to the episode of care. For example, the previous episodes of care include the episodes of care shown in the following:

Care Type:	Start Date	Closed Date	Follow-up Date
Outpatient Rehabilitation	05/15/2005	07/01/2005	08/01/2005
Inpatient Rehabilitation	04/01/2005	05/03/2005	
Continuum of Care - Inpatient	09/09/2004	10/04/2004	
Outpatient Rehabilitation	05/01/2004	06/16/2004	07/16/2004
Inpatient Rehabilitation	03/10/2004	04/01/2004	05/01/2004

Care Type: Inpatient Rehabilitation		
Record Date	Score Type	Instrument
05/03/2005	Finish	DUSOI
05/03/2005	Finish	DUSOI
05/03/2005	Finish	DUSOI
04/01/2005	Start	ASIA

Because there is no Follow-up Date for the episode of care beginning on 04/01/2005, assessments with a score type of Follow-up cannot be added to that episode of care, until a Follow-up Date is assigned to it. The episode of care beginning on 05/01/2004 has a follow-up date of 07/16/2004 so new assessments with a Follow-up score type and a record date of 07/16/2004 may be added to this episode of care.

Impairments Tab

Impairments refer to any loss of psychological, physiological, or anatomical structure or function. Impairments affect organ systems, thought, or emotion. Information about impairments is provided on both the Impairments Tab and the Medical Complications Tab.

Spinal Cord Injury and Disorders Outcomes

Name: SPINALCORD,SIXTEEN Date of Birth: 03/04/1933 (73 yrs.) Neuro. Level: C06 ASIA: C Next AE Due: 12/19/2007
 SSN : 000-00-0016 Education: PR Employment: EP Bladder Drainage: SC Pressure Ulcer: 1

Impairments

CYH Changes Over Time

SF-8 Changes Over Time

DUSOI Changes Over Time

Secondary Conditions:

Date	ICD	Description
05/10/2005	598.9	URETHRAL STRICTURE NOS

Pre-Existing Diagnoses:

Date	ICD	Description
09/08/1998	V65.49	OTHER SPECIFIED COUNSELING
02/18/2003	99401	PREVENTIVE COUNSELING

Pre-Existing Procedures:

Date	CPT	Description
02/18/2003	99401	PREVENTIVE COUNSELING

Assessment Entry Forms

Score	Date	Score	Date
ASIA	C06, C, 07/13/2006 ST	DAST	6, 10/01/2004 FI
AUDIT	13, 10/14/2005 IN	DUSOI	41.5, 07/01/2006 ST
CAGE	4, 10/04/2005 ST	DUSOI-A	81, 10/04/2005 ST
CES-D	10, 10/01/2004 FI	PRIME-MD	1, 07/01/2006 ST
CYH	6, 07/12/2006 UN	SF-8	40.2,40.3,10/04/2005 ST

Body Mass Index (BMI)

Weight: 156.0 Pounds
 Height: 70.0 Inches
 Body Mass Index: 22.2

BMI History: BMI 22.2, 12/04/2006 UN

Navigation: Cover Sheet | Registration | Impairments | Medical Complications | Activities | Participation & SWLS | Reports

Graphs on Impairments Tab

On the Impairments page, the following three graphs are populated after their corresponding assessments have been completed and submitted.

- Check Your Health (CYH) Changes Over Time
- SF-8 Health Survey Changes Over Time
- Duke Severity of Illness Scale (DUSOI) Changes Over Time

By resting the mouse over one of the data points on any of these graphs, the date and the score for that assessment are displayed.

Body Mass Index (BMI)

The BMI section of the Impairments tab displays the patient's current weight (in pounds or kilograms), the patient's height (in inches or centimeters), and the patient's body mass index. The Body Mass Index (BMI) form calculates a Body Mass Index as a measure of body fat based on height and weight that applies to both adult men and women.

To create a new BMI assessment, select the *BMI* button. To view a historic listing of the patient's BMI scores, select the BMI History dropdown. From the BMI History listing, you can select an assessment history line to view and edit an individual assessment.

For more information about the BMI instrument, refer to [Appendix C: Instruments and Forms](#).

Conditions, Diagnoses, and Procedures

Secondary Conditions, Pre-Existing Diagnoses, and Pre-Existing Procedures

The Secondary Conditions, Pre-Existing Diagnoses, and Pre-Existing Procedures display-only fields list the patient's Secondary Conditions excluding SCI Diagnoses, Pre-Existing Diagnoses before the date of SCI onset, and Pre-Existing Procedures occurring before the date of SCI onset within VA health care settings. This information is populated through other applications and cannot be entered or edited.

To view a history of the patient's Secondary Conditions, Pre-Existing Diagnoses, or Pre-Existing Procedures, select the Window Expander icon next to each field.

Swallowing Status Field

The Swallowing Status field is populated from values entered in the Medical Needs and Function Modifiers (MNFM) instrument. The information is display-only text and may be updated only by performing a new MNFM Non-Goal assessment through the Activities page.

Dehydration Signs Field

The Dehydration Signs field is populated from values entered in the Medical Needs and Function Modifiers (MNFM) instrument. The information is display-only text and may be updated by performing a new MNFM assessment through the Activities page.

Brain Injury Field

To indicate whether the patient has ever had a brain injury, select either the *Yes* or *No* radio button.

Other Injury Field

To indicate whether the patient had any injury other than a brain injury at the time of SCID onset, select either the *Yes* or *No* radio button.

Describe Other Field

If the *Yes* button is selected in the Other Injury field, a description of the injury may be entered into the Describe Other field.

Assessment Entry Forms on Impairments Tab

Eleven instruments pertaining to loss of psychological, physiological, or anatomical structure or function are accessed or launched from the Impairments tab:

- ASIA - American Spinal Injury Association Standard Neurological Classification of Spinal Cord Injury
- AUDIT - Alcohol Use Disorders Identification Test
- BMI – Body Mass Index Calculator
- CAGE - Brief alcohol disorder assessment instrument
- CES-D - Center for Epidemiologic Studies - Depression Scale
- CYH - Check Your Health and Secondary Conditions Checklist
- DAST - Drug Abuse Screening Test
- DUSOI - Duke Severity of Illness Checklist Scale

DUSOI-A - Duke Severity of Illness Analog
PRIME-MD - PRIME-MD Depression Screening
SF-8 Health Survey

To access an instrument form, select the button next to the instrument name. For example, select the *ASIA* button to launch the ASIA instrument to create a new ASIA assessment.

Refer to [Appendix C: Instruments and Forms](#) for more information on each instrument.

NOTE: The term “assessment” refers to an instrument that has been completed. In this manual, the term “instrument” will be used for the form that is completed during the assessment process.

Assessment Scores/Dates on Impairments Tab

Next to each assessment entry button is a history field that displays the score(s), score type, and the record date for the most recent assessment. Select the history dropdown to view a listing of the score(s), record dates, and score types for all assessments. You can view (and edit) individual assessments by selecting one of the assessment history lines. Editing assessments is covered in the [Editing Assessments](#) section of this manual.

Medical Complications Tab

Medical complications are impairments that are commonly associated with spinal cord injury. Respiratory complications are the most frequent cause of mortality in the SCI&D population. Urinary tract infections occur frequently but with less mortality than in the past. Pressure ulcers are costly and disruptive to participation in meaningful social roles. Chronic and acute pain is commonly reported by spinal cord injury patients and can be disruptive to activities, participation, and satisfaction with life.

Spinal Cord Injury and Disorders Outcomes

Name: SPINALCORD,SIXTEEN Date of Birth: 03/04/1933 (73 yrs.) Neuro. Level: C06 ASIA: C Next AE Due: 12/19/2007
 SSN: 000-00-0016 Education: PR Employment: EP Bladder Drainage: SC Pressure Ulcer: 1

Medical Complications

Pneumonia and Respiratory
 Ventilator Equip./Supplies: No
 Pneumonia Dx's & Respiratory Report
 Pneumonia Immunizations Report

Pain
 SF-MPQ History
 T-PRI: 16, S-PRI: 16, A-PRI: 0, 07/01/2006 ST
 SF-MPQ Instrument Form
 Pain Assessment & Treatment Report

PUSH Over Time
 Recent PUSH Scores: 9, 07/01/2006 ST

Pressure Ulcers
 Press. Ulcer Risk: 4 = High Risk Risk Record Date: 12/19/2006
 Risk Instrument Used: PS = Pressure Score Prediction Scale
 Risk Instrument History: Instrument: PS, Level: 4, 12/19/2006
 PUSH Instrument Form Pressure Ulcer Report
 Predominant Position at Finish: Sitting Finish Record Date: 12/19/2006
 Is Ulcer Closed/Healed?: Yes (selected) No
 Sitting Time: 7.0 Hours
 Time to Achieve Healing: 16 Days
 Pressure Ulcer Finish History: Closed: Y, Position: S, 7.0 Hrs, 16 Days, 12/19/2006

SF-MPQ and PPI
 SF-MPQ PPI SF-MPQ T-PRI SF-MPQ A-PRI
 SF-MPQ S-PRI

Navigation: Cover Sheet, Registration, Impairments, **Medical Complications**, Activities, Participation & SWLS, Reports

Graphs on Medical Complications Tab

The two graphs on the Medical Complications page, *PUSH Over Time* and *SF-MPQ and PPI*, are populated after the corresponding assessment has been completed and submitted. Present Pain Intensity (PPI) ratings are entered on the SF-MPQ form and may also be displayed from the Vista Vitals application. PPI scores with a value of "99=Unable to Respond" are not graphed. By resting the mouse over one of the data points on any of these graphs, the date and the score for that assessment are displayed.

Located under the *PUSH Over Time* graph is the Recent PUSH Scores history field that shows PUSH scores, their associated record dates, and score types. Select the dropdown to view a listing of the score(s), record dates, and score types for all PUSH assessments. You can view (and edit) individual assessments by selecting one of the PUSH Total Score assessment history lines.

Pneumonia and Respiratory Section

Ventilator Equip./Supplies Field

The Ventilator Equip./Supplies field is populated from other applications with either *Yes* or *No*. *Yes* will be populated in this field when one or more of the specified CPT and HCPCS codes are recorded within

the interval from the present day to five years before. This field may be overwritten. To change the value, select the desired value (*Yes* or *No*) from the dropdown.

Pneumonia and Respiratory Reports

To view the Pneumonia and Respiratory report, select the *Pneumonia & Respiratory Report* button. The Pneumonia and Respiratory Report displays VistA information about increased aspiration risks due to swallowing difficulties or feeding tubes, pneumonia or atelectasis diagnoses, intubation procedures, chest radiology results, sputum laboratory results, and discharge locations following inpatient treatment of pneumonias.

To view the Pneumonia Immunizations report, select the *Pneumonia Immunizations Report* button. The Pneumococcal Immunizations Report displays VistA information about pneumococcal vaccination medications ordered for the patient, and pneumococcal vaccination diagnoses and procedure codes recorded. This report cannot be used to document performance measure conformance due to various methods of recording doses.

Refer to the [Reports Tab](#) section of this manual for more information.

NOTE: All reports are view-only. Information within these reports may not be edited.

Influenza Section

Influenza Reports

To view the Influenza Diagnoses & Treatment report, select the *Influenza Dxs & Treatment Report* button. The Influenza Diagnoses and Treatment Report displays VistA information about influenza-related diagnoses, antiviral medications prescribed, influenza-related microbiology and chemistry laboratory reports, chest radiology results, and discharge locations following inpatient treatment of influenza incidents.

To view the Influenza Immunizations report, select the *Influenza Immunizations Report* button. The Influenza Immunizations Report displays VistA information about influenza vaccination medications ordered for the patient, and influenza vaccination diagnoses and procedure codes recorded. This report cannot be used to document performance measure conformance due to various methods of recording doses.

Refer to the [Reports Tab](#) section of this manual for more information.

NOTE: All reports are view-only. Information within these reports may not be edited.

Urinary Tract Infections Section

Bladder Drainage Field

In the Bladder drainage field, select the predominant urinary device type used by the patient. Multiple options cannot be selected. To view a history of the patient's use of urinary device types, select the history dropdown.

- BA = Bladder Augmentation
- EC = Condom/External Catheter
- IC = Intermittent Catheterization
- IN = Indwelling Catheter
- IP = Ileal Pouch
- SC = Suprapubic Catheter
- SS = Surgical Stent

Urinary Tract Infections Reports

To launch the Urinary Tract Infections report, select the *Urinary Tract Infections Report* button. The Urinary Tract Infections Report displays Vista information about urinary tract diagnoses, surgical procedures, radiological studies of the urinary tract, and urinalysis, microbiology, and CBC laboratory results related to urinary tract infections.

Refer to the [Reports Tab](#) section of this manual for more information.

NOTE: All reports are view-only. Information within these reports may not be edited.

Pressure Ulcers Section

Pressure ulcers are costly and disruptive. Pressure ulcer prevention and treatment information can be tracked in the Pressure Ulcer Section. There are two subsections, separated by the PUSH Instrument form and the *Pressure Ulcer Report* button. The first subsection allows collection of information regarding pressure ulcer risk assessments, and the second subsection allows collection of information after a period of treatment focused on healing of a pressure ulcer.

Pressure Ulcer Risk Subsection

The first subsection that allows collection of information regarding pressure ulcer risk assessment includes four fields. Complete the first three fields and select the *Submit* button to create a Pressure Ulcer Risk Assessment.

Whenever the Risk Record Date field is modified and submitted, if values are present in the Press. Ulcer Risk and Risk Instrument Used fields, a new assessment line is created in the Risk Instrument History field. If the user modifies saved values in the Pressure Ulcer Risk field and/or Risk Instrument Used field and does not modify the Record Date, if the user selects Submit, a message “Duplicate Risk Date” is displayed.

Pressure Ulcer Risk

To indicate the patient’s risk for pressure ulcers, select from the dropdown one of the following values:

- 0 = Not Assessed
- 1 = Very Low Risk
- 2 = Low Risk
- 3 = Average Risk
- 4 = High Risk
- 5 = Very High Risk

Risk Record Date

Record the date the pressure ulcer risk assessment occurred. The date can be manually entered or selected from the Calendar icon.

Risk Instrument Used

To indicate the instrument used to determine the patient’s risk for pressure ulcers, select from the dropdown one of the following commonly used pressure ulcer risk assessment instruments:

- AN = Anderson
- BB = Braden, and Modified Braden
- CJ = Cuben and Jackson Scale
- GM = Gosnell and Modified Gosnell
- KN = Knoll
- NR = Norton
- PS = Pressure Sore Prediction Scale
- SL = Salzberg, Lehman, or Rodriguez
- WP = Waterlow Pressure Sore Risk Calculator
- WT = Watkinson Scale
- NN = None of the Above

Risk Instrument History

The Risk Instrument History field displays the historical values for the patient’s pressure ulcer risk level, the risk instrument used, and the date that the risk assessment was taken. To view a complete history of the patient’s pressure ulcer risk assessments, select the dropdown next to the field.

Pressure Ulcer Scale for Healing (PUSH)

The Pressure Ulcer Scale for Healing (PUSH) instrument) is included to allow recording specific information regarding the patient’s most severe pressure ulcer. To access the PUSH instrument, select the *PUSH Instrument Form* button.

The pressure ulcer is assessed and scored on the four elements in the tool: length of the open wound, width of the open wound, exudate amount, and tissue type. The highest current pressure ulcer stage and number of current pressure ulcers are recorded on the form.

Push scores are displayed under the PUSH Over Time graph in the Recent PUSH Scores field. For more information about the PUSH, refer to [Appendix C: Instruments and Forms](#).

Pressure Ulcer Report

The Pressure Ulcer Report displays SCIDO information entered on the Medical Complications Tab and PUSH assessments. VistA information about pharmacy supplies and prosthetic devices, diagnoses, surgeries, complications, radiological studies, and laboratory results related to pressure ulcers is also displayed.

To view the Pressure Ulcer Report, select the *Pressure Ulcer Report* button.

Pressure Ulcer Finish Subsection

The second Pressure Ulcer subsection allows collection of information after a period of treatment focused on healing of a pressure ulcer. Complete the first five fields and select the *Submit* button to create a Pressure Ulcer Finish Assessment.

Whenever the Finish Record Date field is modified and submitted, if values are present in the other required fields, a new assessment line is created in the Pressure Ulcer Finish History field. If the user modifies saved values in the other fields and does not modify the Finish Record Date, if the user selects Submit, a message “Duplicate Finish Date” is displayed.

Predominant Position at Finish

To indicate the patient’s predominant position at the finish of their pressure ulcer healing, select from the dropdown one of the following values:

- Sitting
- Bedrest

Finish Record Date

Next to the Predominant Position at Finish field is a date field for recording when the assessment occurred. The date can be manually entered or selected by selecting the Calendar icon.

Is Ulcer Closed/Healed

Select either the *Yes* or *No* radio button to indicate whether the patient’s pressure ulcer is closed or healed.

Sitting Time (Hours/Day)

Enter the number of hours of sitting tolerance time per day, for example 5.25. Valid values are 0 to 24.00.

Time to Achieve Healing (Days)

Enter the time in days that it took for the highest staged ulcer to heal.

Pressure Ulcer Finish History

This field displays the most recent Pressure Ulcer Finish values for the patient’s predominant position at finish, whether the pressure ulcer is closed and healed, the sitting time, the time to achieve healing, and the date that the assessment was conducted. To view a complete history of the patient’s pressure ulcer periods of treatment, select the history dropdown next to the field.

Pain Section

Short Form McGill Pain Questionnaire (SF-MPQ)

The Short Form McGill Pain Questionnaire (SF-MPQ) is included to allow recording of a patient's subjective pain experience along two dimensions of pain, sensory pain rating index (S-PRI) and affective pain rating index (A-PRI), and a total pain rating index (T-PRI). The patient is also provided the opportunity to rate their present pain intensity index (PPI) and use a visual analogue scale to rate their pain from zero (lowest severity) to one-hundred (highest severity).

SF-MPQ History

The SF-MPQ History field displays the patient's Short Form McGill Pain Questionnaire assessment scores with the score type and record date. To view a complete history of the patient's SF-MPQ assessments, select the dropdown next to the field.

Pain Assessment & Treatment Report

The Pain Assessment & Treatment Report displays SF-MPQ and PPI scores, pain alleviation drugs, pain management diagnoses and procedures, and Transcutaneous Electrical Nerve Stimulation (TENS) trial dates. Present Pain Intensity ratings may be from either the SF-MPQ or the VistA Vitals application. To view the Pain Assessment & Treatment Report, select the *Pain Assessment & Treatment Report* button.

Activities Tab

Activities are tasks and actions by an individual at the level of a person rather than the anatomic/physiological level or social level. Activities have been associated traditionally with abilities, disabilities, or independence.

Spinal Cord Injury and Disorders Outcomes

Name: SPINALCORD,SIXTEEN Date of Birth: 03/04/1933 (73 yrs.) Neuro. Level: C06 ASIA: C Next AE Due: 01/17/2007
 SSN: 000-00-0016 Education: PR Employment: UU Bladder Drainage: SC Pressure Ulcer: 3

Activities

Assessment Forms	Recent Scores	Benchmark
FIM	FIM Total: 36, 09/01/2005 FI	66
FAM	FIM Motor: 26, 09/01/2005 FI	33 (30-44)
MNFM	FIM Cognitive: 10, 09/01/2005 FI	33
EDSS	FAM: 05/15/2004 IN, Swallowing: 7, Car Transfers: 6, Community Access: 5, Reading: 6, Writi	
FSS	Bowel Accident Frequency: 5, 06/14/2004 FI	
	Bladder Accident Frequency: 5, 06/14/2004 FI	
	Kurtzke EDSS Rating: 4.0, 05/15/2005 ST	
	FSS: 07/01/2005 FI, Pyr: 3, Crbrlr: 3, BS: 2, Sens: 3, BB: 3, Vis: 2, Men: 3, Oth: 0	

FIM

FAM

Kurtzke FSS & EDSS

Accident Frequency

Print Help

Cover Sheet Registration Impairments Medical Complications Activities Participation & SWLS Reports

Graphs on Activities Tab

The four graphs on the Activities page, Functional Independence Measure (FIM), Functional Assessment Measure (FAM), Kurtzke FSS & EDSS, and Accident Frequency graphs, are populated after their corresponding assessment has been completed and submitted. By resting the mouse over one of the data points on any of these graphs, the date and the score for that assessment are displayed.

Activities Tab Assessment Entry Forms, Scores, and Benchmarks

NOTE: Benchmarks will not display for ASIA Impairment E or Unknown.

Functional Independence Measure (FIM)

The Functional Independence Measure (FIM) is the most widely used activity or functional assessment measure in the rehabilitation community. To access the FIM instrument, select the *FIM* button. For more information about the FIM, refer to [Appendix C: Instruments and Forms](#).

FIM Total Score, Date, and Benchmark

The FIM Total score, date, score types, and benchmark fields are populated after a FIM assessment has been completed and submitted. FIM Total scores, dates, and score types are displayed in a FIM history field, starting with the most recent assessment. Select the dropdown to view a listing of the score(s),

record dates, and score types for all FIM assessments. You can view (and edit) individual assessments by selecting one of the FIM Total Score assessment history lines.

FIM Motor Score, Date, and Benchmark

FIM Motor scores, dates, score types, and benchmarks are displayed in a history field. Select the dropdown to view a listing of all FIM Motor score(s), record dates, and score types. To view (and edit) individual assessments, select one of the assessment history lines for the FIM Total Score field.

FIM Cognitive Score, Date, and Benchmark

FIM Cognitive scores, dates, score types, and benchmarks are displayed in a history field. Select the dropdown to view a listing of all FIM Cognitive score(s), record dates, and score types. To view (and edit) individual assessments, select one of the assessment history lines for the FIM Total Score field.

Functional Assessment Measure (FAM)

The Functional Assessment Measure (FAM) was developed as an activity measure and as an adjunct to the Functional Independence Measure (FIM). To access the FAM instrument, select the *FAM* button. For more information about the FAM, refer to [Appendix C: Instruments and Forms](#).

FAM Scores

Beside the *FAM* button is a history field that displays the most recent FAM score. This field is populated after a FAM assessment has been completed and submitted. Select the dropdown to view a listing of the scores, record dates, and score types for all FAM assessments. You can view (and edit) an individual FAM assessment by selecting one of the FAM assessment history lines.

MNFM Form

To access the Medical Needs and Function Modifiers (MNFM) instrument, select the *MNFM* button. For more information about the MNFM instrument, refer to [Appendix C: Instruments and Forms](#).

Bowel Accident Frequency

The Bowel Accident Frequency field is populated after an MNFM assessment has been completed and submitted. The frequency of bowel accident rating, record dates, and score types are displayed in a history field. Select the dropdown to view a listing of the score(s), record dates, and score types for all MNFM assessments. You can view (and edit) an individual MNFM assessment by selecting one of the assessment history lines.

To access the MNFM instrument, select the *MNFM* button.

Bladder Accidents Frequency

The Bladder Accident Frequency field is populated after an MNFM assessment has been completed and submitted. The frequency of bladder accident rating and dates are displayed in a history field. Select the dropdown to view a listing of the score(s), record dates, and score types for all MNFM assessments. You can view (and edit) individual MNFM assessments by selecting one of the assessment history lines.

To access the MNFM instrument, select the *MNFM* button.

Kurtzke Expanded Disability Status Scale (EDSS)

To access the Kurtzke EDSS instrument, select the *EDSS* button.

NOTE: The EDSS and FSS assessments will only be available if the patient holds an etiology of Multiple Sclerosis.

Refer to [Appendix C: Instruments and Forms](#) for more information on the Kurtzke EDSS instrument. The Kurtzke EDSS Rating field is populated after a Kurtzke EDSS assessment has been completed and submitted. Kurtzke EDSS scores, record dates, and score types are displayed in a history field. Select the dropdown to view a listing of the score(s), record dates, and score types for all EDSS assessments. You can view (and edit) individual assessments by selecting one of the assessment history lines.

Kurtzke Functional Systems Scale (FSS)

To access the Kurtzke FSS instrument, select the *FSS* button. Refer to [Appendix C: Instruments and Forms](#) for more information on the Kurtzke FSS instrument.

FSS scores and dates are displayed in a history field next to the *FSS* button. Select the history dropdown to view a listing of the score(s), record dates, and score types for all FSS assessments. You can view (and edit) individual FSS assessments by selecting one of the assessment history lines.

Participation & SWLS Tab

Participation reflects the nature and extent of a person’s involvement in life situations at a social or societal level and often pertains to participating in meaningful social roles. This tab summarizes participation information based on the Craig Handicap Assessment and Reporting Technique Short Form (CHART-SF). It also includes Diener’s Satisfaction with Life Scale (SWLS). Global life satisfaction from the patient’s perspective is distinguished from affective appraisal in that it is more cognitively than emotionally driven.

SCIO Patient Search
Spinal Cord Injury and Disorders Outcomes
Logout

Name: SPINALCORD,TWELVE
SSN: 000-00-0012

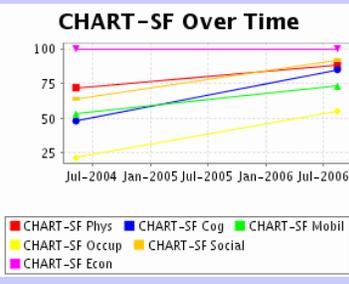
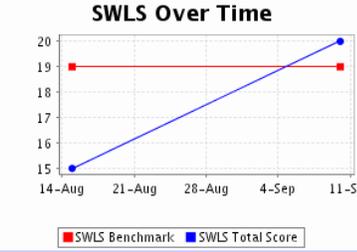
Date of Birth: 04/04/1970 (36 yrs.)
Education: CG

Neuro. Level: C07
Employment: EP

ASIA: C
Bladder Drainage:

Next AE Due: 12/20/2007
Pressure Ulcer: 1

Participation & SWLS

 <p>CHART-SF Over Time</p> <p>Jul-2004 Jan-2005 Jul-2005 Jan-2006 Jul-2006</p> <p> <input type="checkbox"/> CHART-SF Phys <input type="checkbox"/> CHART-SF Cog <input type="checkbox"/> CHART-SF Mobil <input type="checkbox"/> CHART-SF Occup <input type="checkbox"/> CHART-SF Social <input type="checkbox"/> CHART-SF Econ </p>	<p>Social</p> <p>Marital Status: MARRIED</p> <p>Number in Household: 2</p> <p>Metro/Micro/Rural:</p> <p style="text-align: center;">Assessment Entry Forms</p> <p style="text-align: center;"> <input type="button" value="CHART-SF"/> <input type="button" value="SWLS"/> </p> <p style="text-align: center;"> CHART-SF History SWLS History 493.0, 08/15/2006 ST 20, 09/10/2006 FI </p>	<p>Occupation and Education</p> <p>Employment Status: EP = Employed Part Time</p> <p>Education: CG = College Graduate</p> <p>Student?: <input checked="" type="radio"/> Yes <input type="radio"/> No 05/15/2004 Y 05/15/2004</p> <p>Volunteer?: <input checked="" type="radio"/> Yes <input type="radio"/> No 05/15/2004 Y 05/15/2004</p> <p>Current Occupation: Electronics Technician</p> <p>Occupation at Injury: PR = Professional and Technical</p> <p>School: 0.0 Hrs/Week Employment Hours: 10.0 Hrs/Week Homemaking: 5.0 Hrs/Week Home Maintenance: 3.0 Hrs/Week Recreation: 8.0 Hrs/Week</p>																					
<p>Attendant Care</p> <p>Attendant Care: 3.0 Hrs/Day</p> <p>Paid Attendant Care: 2.0 Hrs/Day</p> <p>Unpaid Attendant Care: 1.0 Hrs/Day</p> <p>Att. Care Interruption Dates: 07/11/2006</p> <p>Attendant Loss Admissions: 07/12/2005</p> <p>Att. Care Interruptions in 5 Yrs: 1 07/11/2006</p> <p>Att. Loss Admissions in 5 Yrs: 1 07/12/2005</p>	<p>CHART-SF Subscales</p> <table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th>Subscale</th> <th>Current and Historic</th> <th>Benchmark</th> </tr> </thead> <tbody> <tr> <td>Physical:</td> <td>88.0, 08/15/2006 ST</td> <td>84 (52-94)</td> </tr> <tr> <td>Cognitive:</td> <td>85.0, 08/15/2006 ST</td> <td></td> </tr> <tr> <td>Mobility:</td> <td>73.0, 08/15/2006 ST</td> <td>84 (59-100)</td> </tr> <tr> <td>Occupation:</td> <td>55.0, 08/15/2006 ST</td> <td>50 (18-95)</td> </tr> <tr> <td>Social:</td> <td>92.0, 08/15/2006 ST</td> <td>95 (70-100)</td> </tr> <tr> <td>Economic:</td> <td>100.0, 08/15/2006 ST</td> <td>50 (25-100)</td> </tr> </tbody> </table>	Subscale	Current and Historic	Benchmark	Physical:	88.0, 08/15/2006 ST	84 (52-94)	Cognitive:	85.0, 08/15/2006 ST		Mobility:	73.0, 08/15/2006 ST	84 (59-100)	Occupation:	55.0, 08/15/2006 ST	50 (18-95)	Social:	92.0, 08/15/2006 ST	95 (70-100)	Economic:	100.0, 08/15/2006 ST	50 (25-100)	 <p>SWLS Over Time</p> <p>14-Aug 21-Aug 28-Aug 4-Sep 11-Sep</p> <p> <input type="checkbox"/> SWLS Benchmark <input checked="" type="checkbox"/> SWLS Total Score </p>
Subscale	Current and Historic	Benchmark																					
Physical:	88.0, 08/15/2006 ST	84 (52-94)																					
Cognitive:	85.0, 08/15/2006 ST																						
Mobility:	73.0, 08/15/2006 ST	84 (59-100)																					
Occupation:	55.0, 08/15/2006 ST	50 (18-95)																					
Social:	92.0, 08/15/2006 ST	95 (70-100)																					
Economic:	100.0, 08/15/2006 ST	50 (25-100)																					

Cover Sheet
Registration
Impairments
Medical Complications
Activities
Participation & SWLS
Reports

Graphs on Participation & SWLS Tab

The two graphs on the Participation & SWLS page are populated after the corresponding assessment (CHART-SF or SWLS) has been completed and submitted. CHART-SF benchmark information is not provided in the graph but is available in the center column of the tab. The SWLS Over Time graph displays benchmark information based on the highest ASIA Neurological level, ASIA impairment scale, clinical practices guideline, and research publications.

NOTE: Benchmarks will not display for ASIA Impairment E or Unknown.

By resting the mouse over one of the data points on any of these graphs, the date and the score for that assessment are displayed.

Attendant Care Section of Participation and SWLS Tab

Attendant Care Field

The Attendant Care field displays the sum of the number of paid and unpaid hours of attendant care per day. The Attendant Care field is populated after the Physical Independence subscale of a CHART-SF Non-Goal assessment has been completed and submitted.

Paid Attendant Care Field

The Paid Attendant Care field displays the number of hours of paid attendant care per day. This field is populated after the Physical Independence subscale of a CHART-SF Non-Goal assessment has been completed and submitted.

Unpaid Attendant Care Field

The Unpaid Attendant Care field displays the number of hours of unpaid attendant care per day. This field is populated after the Physical Independence subscale of a CHART-SF Non-Goal assessment has been completed and submitted.

Att. Care Interruption Dates Field

The Attendant Care Interruption Dates field has a date field for recording when the patient experienced an unplanned disruption in personal attendant care. The date can be manually entered or selected by selecting the Calendar icon to designate the date when the incident occurred.

Attendant Loss Admissions Field

The Attendant Loss Admissions field has a date field for recording when the patient had to be admitted to a health care or extended care facility due to an unplanned disruption in personal attendant care. The date can be manually entered or selected by selecting the Calendar icon to designate the date when the incident occurred.

Attendant Care Interruptions in 5 Years Field

The Attendant Care Interruptions in 5 Yrs field is display-only and is calculated and populated from the Attendant Care Interruption Dates.

Attendant Loss Admissions in 5 Years Field

The Attendant Loss Admissions in 5 Yrs. field is display-only and is calculated and populated from the Attendant Loss Admissions field.

Social Section of Participation and SWLS Tab

Marital Status Field

The Marital Status field is display-only and is populated by other applications.

Number in Household Field

The Number in Household Field is display-only and is populated after the Social Integration subscale of a CHART-SF Non-Goal assessment has been completed and submitted.

Metro/Micro/Rural Field

The Metro/Micro/Rural field is display-only and is populated by other applications. This field displays the classification of the patient's residence based on their home address. A metropolitan area is one that has more than 50,000 residents. A micropolitan area has 10,000 to 49,999 residents. Areas with less than 10,000 residents are considered rural.

Assessment Entry Forms on Participation & SWLS Tab

Two instruments, the CHART-SF and Diener's SWLS, are accessed from the Participation & SWLS tab.

CHART-SF Assessment Entry Form

Select the *CHART-SF* button to launch the Craig Handicap Assessment and Reporting Technique – Short Form (CHART-SF) instrument. For more information, refer to [Appendix C: Instruments and Forms](#).

CHART-SF History

The CHART-SF History field displays CHART-SF scores, record dates, and score types. Clicking on an assessment history line will open that assessment for viewing and editing.

Diener's Satisfaction with Life Scale (SWLS) Assessment Entry Form

Select the *SWLS* button to launch Diener's Satisfaction with Life Scale (SWLS) instrument.

For more information about the SWLS instrument, refer to [Appendix C: Instruments and Forms](#).

SWLS History

The SWLS History field displays SWLS scores, record dates, and score types. Clicking on an assessment history line will open that assessment for viewing and editing.

CHART-SF Subscales Section

The CHART-SF Subscales section of the Participation & SWLS page contains the following subscales:

- Physical (Current, Historic, Benchmark)
- Cognitive (Current, Historic)
- Mobility (Current, Historic, Benchmark)
- Occupation (Current, Historic, Benchmark)
- Social (Current, Historic, Benchmark)
- Economic (Current, Historic, Benchmark)

Next to the subscales are fields that display CHART-SF scores and their associated record dates and score types. These fields are populated after a CHART-SF Non-Goal assessment has been completed and submitted. Clicking on an assessment history line will open that assessment for viewing and editing.

NOTE: if any CHART-SF sub-section besides the required Physical Independence section, is not completed, the CHART-SF Total score and edit/view total score is blank

Next to the subscale field is the CHART-SF Benchmark for that particular subscale. The Benchmark fields are view-only and are based upon the Veteran's ASIA neurological level and ASIA impairment derived from the Consortium for Spinal Cord Medicine (CSCM) Outcomes Clinical Practices Guideline (CPG) or Model Spinal Cord Injury System (MSCIS) data. Benchmark information for the Cognitive Independence subscale is currently unavailable.

Occupation and Education Section

Occupation and Education

Employment Status: EP = Employed Part Time

Education: PR = Graduate or Professional School

Record Date: History

Student?: Yes No 12/19/2006 N 12/19/2006

Record Date: History

Volunteer?: Yes No 12/19/2006 N 12/19/2006

Current Occupation: Electronics Technician

Occupation at Injury: PR = Professional and Technical

School: 4.0 Hrs/Week Employment Hours: 20.0 Hrs/Week

Homemaking: 5.0 Hrs/Week Home Maintenance: 4.0 Hrs/Week

Recreation: 4.0 Hrs/Week

The Occupation and Education Section of the Participation & SWLS tab includes the following fields:

Employment Status Field

Select the Veteran's current employment status from the following:

- EF = Employed Full Time
- EP = Employed Part Time
- RT = Retired
- UU = Unemployed
- NN = Unknown

Education Field

This field displays the value selected and saved in the [Highest Level of Education](#) field on the Registration page.

- LH = Less than High School Graduate
- HS = High School Graduate or GED
- SC = Some College, Technical School, AA, or AS
- CG = College Graduate
- PR = Graduate or Professional School

Student? Field

Select either *Yes* or *No* to indicate whether the Veteran participates in education activities.

In the date field to the right, enter the date the person participated in education activities.

Student History

Previous student entries and associated dates are displayed in a history dropdown.

Volunteer? Field

Select either *Yes* or *No* to indicate whether the Veteran participates in volunteer activities. In the date field to the right, enter the date the Veteran participated in volunteer activities. Previous volunteer entries and associated dates are displayed in a dropdown, starting with the most recent entry.

Current Occupation Field

This field displays the occupation text entered in the most recently completed CHART-SF assessment.

Occupation at Injury Field

This field displays the patient's type of occupation at the time of spinal cord injury or onset. It is populated from the [Occupation at Time of Injury](#) field in the Registration Tab. Department of Labor Occupation types include:

- PR = Professional and technical
- EX = Executive
- SL = Sales
- AD = Administrative support
- PP = Precision Production
- MO = Machine Operators
- TR = Transportation
- HA = Handlers
- SV = Service

Information from the CHART-SF Assessment

The following information from the most recently completed CHART-SF assessment is displayed:

- School Hours/Week
- Employment Hours/Week
- Homemaking Hours/Week
- Home Maintenance Hours/Week
- Recreation Hours/Week

Assessment Entry Forms

The SCIDO application contains 20 instruments or assessment entry forms. The headers of most instruments are similar in appearance.

Name:	SPINALCORD,FOURTEEN	* Record Date:	09/01/2005 
Division:	442	Care Start Date:	
* Care Type:		* Score Type:	
Score:	0		

After an assessment entry button has been selected from a Tab, the application displays the instrument with the patient name and division in the header of that instrument. Other values, such as Care Type and Care start date, may default into the form, but usually can be modified.

Some instruments do not contain a score field in the header. Some instruments such as Check Your Health (CYH) and SF-8 Health Survey will have extra score fields in the header.

Fields that must be completed to calculate or save the assessment are marked with a red asterisk as a reminder of their required status. Other unmarked fields may be required for some assessments depending on the values selected for the form. For example, if part of one section of the CHART-SF is completed, then that entire section must be completed.

Header of Assessments

The header of most assessment forms contains the following fields.

Name Field

The Name field is display-only.

Record Date Field

The Record date is the date the assessment was performed by the Clinician or other care provider. This may be any date up to and including the current date. A future date cannot be used. The user may either manually enter the date or select the date from a calendar supplied with the form.

Division Field

The Division field is display-only and is populated by the application.

Care Type Field

The Care Type field may contain one of the following values:

- Inpatient Rehabilitation
- Outpatient Rehabilitation
- Continuum of Care - Inpatient
- Continuum of Care - Outpatient
- Annual Evaluation
- SCI Home Care
- Extended Care
- End of Life Care
- Numeric Protocol Codes = 9-99

NOTE: The care types of Inpatient Rehabilitation, Outpatient Rehabilitation, or Continuum of Care - Inpatient are used if there is an Episode of Care associated with the assessment. Refer to the [Episodes of Care](#) section of this manual for further information.

Care Start Date Field

The Care Start Date field is display-only and is populated by the application when an assessment belongs to an episode of care. Refer to the section in this manual on [Episodes of Care](#).

Score Field

Most assessment forms have one or more score fields, calculated by the application.

Score Type Field

For the Score Type, the following choices are available.

Start = ST	A score type of “Start” is used to identify the beginning of a treatment or rehabilitation episode of care. It rarely is the same date that the patient is admitted to the medical center.
Goal = G	A “Goal” score type is used to identify goals that the patient is realistically expected to achieve on a particular assessment at the close of an episode of care.
Interim = IN	“Interim” score types are used to track patient progress in increments between the start and finish of treatment services.
Finish = FI	A “Finish” score type is used to identify the patient’s status at the end of a treatment or rehabilitation episode of care. It is rarely the same date that the patient is discharged from the medical center
Follow-up = FO	A “Follow-up” score type is used to identify if the patient’s status has been maintained at some time following completion of treatment or rehabilitation. The score type of Follow-Up may be used if there is a closed Episode of Care associated with the assessment.
Unknown = UN	An “Unknown” score type should be used when a sequencing of score types is not indicated or when none of the previous score types are applicable. For example, assessments with a care type of Annual Evaluation would likely have “Unknown” score types.

If an assessment is part of an Episode of Care, rules will apply to which score types are available for each instrument type. Refer to the [Episodes of Care](#) section in this manual for further information.

NOTE: The term “assessment” refers to an instrument that has been completed. In this manual, the term “instrument” is used for the form completed during the assessment process.

Button Functions on Assessments

Most instrument forms contain the following buttons on each form.

Back Button

Select the *Back* button to return to the previous page.

Print Button

Select the *Print* button to print the assessment, including all responses that have been entered or selected.

The print function may be used at any time to make a paper copy of the completed assessment. The *Print* button is often used after the calculate function and before the submit function is used.

Blank Forms

Select the *Blank Forms* button to print a blank form in PDF format. The application will display the Blank Forms page with a list of all instruments. Select the Print icon by the desired instrument to print a blank instrument form. To view the Blank Forms page, refer to the section called [Blank Assessment Forms](#).

Cancel Button

Select the *Cancel* button to exit the assessment form and return to the page from which it was launched. For example, when in the ASIA instrument, selecting the *Cancel* button returns the user to the Impairments page.

NOTE: If any information was entered into the instrument or form, it will be lost when the *Cancel* button is selected.

Reset Button on Instruments

Select the *Reset* button to return to the most recently saved values on the form.

NOTE: When the Calculate function has been used on a form, the Reset function on instruments returns the values entered or edited up to the Calculate function. The form values are not necessarily returned as the values when the form was first opened, but to the values when the form was last calculated.

Calculate Button on Assessments

Select the *Calculate* button to calculate and display the instrument score(s), if any.

Submit Button on Assessments

Select the *Submit* button to submit the data to the regional database. The system will display either an information message or a message that the assessment information was saved successfully.

Select OK to return to the previous page.

Help Button on Assessments

Select the *Help* button to access Online Help.

Calendar on Assessments

The Calendar icon provides the user with a calendar from which to select a date. The calendar function in an instrument works the same as the Calendar icon on tabs. Refer to the section called [Calendar](#) in this manual.

General Procedure for Creating Assessments

Depending on the assessment type, the rules for creating, calculating, and submitting an assessment will vary. The basic procedure for creating a new assessment is described below.

Creating a New Assessment

1. Gather the assessment information.
2. Use Patient Look-up to locate the patient in the application.
3. Open the appropriate SCI Tab to locate the assessment form button.
4. Select the assessment form button. The application will display the selected online form with the patient's name and division.
5. Manually enter the Record Date on which the assessment information was gathered or select the date from the Calendar.
6. Select one of the following Care Types:
 - Inpatient Rehabilitation (requires episode of care [EoC] management)
 - Outpatient Rehabilitation (requires episode of care [EoC] management)

Continuum of Care – Inpatient (requires episode of care [EoC] management)
Continuum of Care – Outpatient
Annual Evaluation
SCI Home Care
Extended Care
End of Life Care
Or one of 91 specific protocols of care

7. For some types of assessments (those with an EoC care type) a value may be displayed in the Care Start Date field. For EoC care types with Follow-up score types, a value is selected from the Care Start Date field.
8. Select one of the following score types:
 - Start
 - Goal
 - Interim
 - Finish
 - Follow-up
 - Unknown
9. Complete all required fields. Complete any desired optional fields.
10. Select the *Calculate* button. The application will calculate the score(s).
11. Select the *Submit* button. The application will provide notification when the assessment information was saved successfully.
12. Select *OK*. The application will return to the tab from which the instrument is accessed.

Editing Assessments

Assessments may be viewed and edited. Some fields in the header, such as the care type and score type fields, cannot be modified. Special rules may apply for some assessments. For example, when editing a DUSOI assessment, the user will not be able to edit the record date.

NOTE: The user may modify the responses on the assessment form, subject to the rules that apply to entering an assessment and the rules that apply for the particular assessment form.

Editing an Assessment, General Procedure

1. Open the appropriate Tab page. See the [Instruments](#) section in this manual for the tab location of each assessment entry form button.
2. Next to the desired assessment entry form button, select the History dropdown to display a listing of score(s), record dates, and score types for all assessments.
3. Select the desired assessment history line by clicking on it.
4. The application asks if you are sure you want to edit the assessment. Select *OK*.
5. The Application displays the completed assessment form.
6. View and modify the form subject to the rules that apply to creating, modifying, and saving all assessments and subject to the rules that apply to that particular assessment form.
7. Upon completion of all edits, select the *Calculate* button.
8. Select the *Submit* button.

Refer to [Appendix C: Instruments and Forms](#) for details about individual assessments or instruments.

Blank Assessment Forms

Select the *Blank Forms* button from any assessment form to print a blank form in PDF format. The application will display the Blank Forms page with a list of all instruments. Select the Print icon by the desired instrument to print a blank instrument form. These forms are particularly useful for completion at the bedside. The assessment information can be entered into the application later from the handwritten form.

Blank Forms (PDF)

Printing a PDF requires that you have the Adobe® Reader® installed on your computer. If it is not already on your system, click on the Get Adobe® Reader® icon to download Adobe Reader. For a blank form, click on the printer icon associated with the form you want. This will bring up a PDF that you can print or save to your computer.



American Spinal Injury Association Standard Neurological Classification of Spinal Cord Injury (ASIA)	
Alcohol Use Disorders Identification Test (AUDIT)	
Body Mass Index (BMI)	
CAGE	
Center for Epidemiologic Studies Depression Scale (CES-D)	
Craig Handicap Assessment and Reporting Technique Short Form (CHART-SF)	
Check Your Health (CYH) and Secondary Conditions	
Drug Abuse Screening Test (DAST)	
Duke Severity of Illness (DUSOI) Checklist	
Duke Severity of Illness Analog (DUSOI-A) Scale	
Functional Assessment Measure (FAM)	
Functional Independence Measure (FIM)	
Kurtzke Expanded Disability Status Scale (EDSS)	
Kurtzke Expanded Disability Status Scale (EDSS) Full Text	
Kurtzke Functional Systems Scale (FSS)	
Kurtzke Functional Systems Scale (FSS) Full Text	
Medical Needs functions Modifier (MNFM)	
Patient Education	
PRIME-MD Depression Screening	
PUSH Tool	
Satisfaction With Life Scale (SWLS)	
SF-8™ Health Survey	
Short Form McGill Pain Questionnaire (SF-MPQ)	

Back
Help

Progress Notes

Progress notes may be created, signed, and submitted to CPRS-R for the following instruments:

- Craig Handicap Assessment and Reporting Technique – Short Form (CHART-SF)
- Functional Independence Measure (FIM)
- Satisfaction with Life Survey (SWLS) (Diener’s)

For all three instruments, the system will prompt the user to write progress notes for the following combinations of score type and care type:

- Score Type of Start and Care Type of Inpatient Rehabilitation (Goal-setting)
- Score Type of Start and Care Type of Outpatient Rehabilitation (Goal-setting)
- Score Type of Finish and Care Type of Inpatient Rehabilitation
- Score Type of Finish and Care Type of Outpatient Rehabilitation
- Score Type of Follow-up and Care Type of Inpatient Rehabilitation
- Score Type of Follow-up and Care Type of Outpatient Rehabilitation

For the Functional Independence Measure (FIM), the user can elect to enter a free-text progress note that will be sent to CPRS for further authentication and entry. In addition to the combinations listed above, for the FIM, the system will prompt the user to write a progress note for the following combinations of score type and care type:

- Score Type of Goal and Care Type of Inpatient Rehabilitation
- Score Type of Goal and Care Type of Outpatient Rehabilitation
- Score Type of Goal and Care Type of Continuum of Care--Inpatient
- Score Type of Start and Care Type of Continuum of Care—Inpatient
- Score Type of Finish and Care Type of Continuum of Care—Inpatient
- Score Type of Follow-up and Care Type of Continuum of Care—Inpatient
- Any Score Type and Care Type that is a Non-Episode of Care
- Score Type of Interim and any Episode of Care Type
- Score Type of Unknown and any Episode of Care Type

In addition to care type and score type, other variables or conditions (e.g., the ASIA Neurologic Level value and ASIA Impairment value), will determine whether the user is prompted with an information message with an opportunity to write a progress note. After submitting one of these assessments, within the information message about progress note, the user can select either *Yes* to write a progress note or *No* to not write a progress note. For example, after creating and selecting the *Submit* button for a CHART-SF with a score type of Start and care type of Inpatient Rehabilitation, the system responds with an information message:

CHART-SF Information Message	
You have entered a care type of either Inpatient Rehabilitation or Outpatient Rehabilitation for a patient with a C07 ASIA neurological level and an ASIA impairment scale of C. Do you want to see a goal-setting template you use to generate a CPRS progress note?	
Yes	No

Example of a CHART-SF Progress Note with Goal Template

The application displays a goal template when the score type for the patient is Start and the care type is either Inpatient Rehabilitation or Outpatient Rehabilitation.

CHART-SF Subscale Scores						
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	Physical	Cognitive	Mobility	Occupation	Social	Economic
Start	96.0	100.0	97.0	91.3	100.0	86.3
Median	100		100	66	100	100
Interquartile Range	94-100		77-100	29.5-100	75-100	50-100
Goal	<input type="text"/>					
<input type="button" value="Submit"/>						

Select the Visit Location from the list in the dropdown field.

Select the Service Type from the list of types in the dropdown field.

Enter the goal for each subscale and select *Submit*. The application responds with the form that will be submitted to CPRS.

Motor Efficiency and Cognitive Efficiency display up to 2 post-decimal places:

$$\text{Motor Efficiency} = (\text{Motor Finish Score} - \text{Motor Start Score}) / \text{Length of Rehab}$$

$$\text{Cognitive Efficiency} = (\text{Cognitive Finish Score} - \text{Cognitive Start Score}) / \text{Length of Rehab}$$

$$\text{Length of Rehabilitation} = (\text{Care finish date} - \text{Care start date} - [\text{Length of 3 longest interruptions in care}])$$

To save the progress note, the user must enter their electronic signature code and select *Submit*.

NOTE: the Visit Location, Service Type, and Electronic Signature Code are required fields.

Spinal Cord Injury & Disorders Outcomes
 Progress Notes

Progress Notes Title:

Visit Location: *

Service Type: *

CHART-SF Subscale Scores						
	Physical	Cognitive	Mobility	Occupation	Social	Economic
Start	96.0	100.0	97.0	91.3	100.0	86.3
Median	100		100	66	100	100
Intrqrtl	94-100		77-100	29.5-100	75-100	50-100
Goal	98	100	98	95	90	90

*** Enter Electronic Signature Code:**

Reports Tab

The Reports Tab provides access to the various reports that can be generated by the application. The benefits of accurately maintaining the SCIDO application for Veterans with spinal cord injuries or disorders are reflected in the reports.

NOTE: Access to certain reports is limited to the specific role of the user (Administration, Clinician, or Researcher).

Spinal Cord Injury and Disorders Outcomes

SCIDO Patient Search
 Name: SPINALCORD,FOURTEEN
 SSN: 000-00-0014
 Date of Birth: 10/23/1946 (61 yrs.)
 Education:
 Neuro. Level: S02
 Employment: RT
 ASIA: B
 Bladder Drainage:
 Next AE Due:
 Pressure Ulcer:
 Logout

SCI WEB

Impairments and Medical Complications Reports	Filtered Reports	Custom Reports
Influenza Diagnoses & Treatment Influenza Immunizations Report Pain Assessment and Treatment Pneumococcal Immunizations Pneumonia and Respiratory Report Pressure Ulcer Report RAI-MDS Quality Indicators RAI-MDS Resource Utilization Groups (RUG) Urinary Tract Infections Report	Basic Patient Information Breakdown of Patients Current Inpatients Expanded Patient Listing Patients with Future Appointments Follow-Up Last AE Received Follow-Up (Last Seen) Inpatient Outpatient Activity Inpatient Outpatient Activity (Specific) at Your Division Laboratory Utilization at Your Division Laboratory Utilization (Specific) at Your Division Mailing Labels MS (Kurtzke) Measures New SCI&D Patients Patient Listing Patient Listing by State & County Pharmacy Utilization at Your Division Pharmacy Utilization (Specific) at Your Division Prosthetics Utilization at Your Division Prosthetics Utilization (Specific) at Your Division Radiology Utilization at Your Division	Select the Report Designer button to create a custom report to your specifications. The Report Designer allows you to select criteria, format, and information needed for a report. <input type="button" value="Report Designer"/> <input type="button" value="Print"/> <input type="button" value="Help"/>
Cumulative Reports Annual Evaluation Outcomes Continuum of Care Inpatient Outcomes Inpatient Rehabilitation Outcomes Outpatient Rehabilitation Outcomes		
Patient Listing(s) Reports Admissions (SCI&D) Applications for Inpatient Care Community Discharges Discharges (SCI&D) ICD Code Search Patient Education Report Patient Summary Report Readmissions Report		

Cover Sheet | Registration | Impairments | Medical Complications | Activities | Participation & SWLS | Reports | Admin Page

The Reports page contains reports sorted into the following groups:

- Impairments and Medical Complications Reports
- Cumulative Reports
- Patient Listing(s) Reports
- Filtered Reports
- Custom Reports

Preformatted reports regarding impairments and medical complications, aggregate outcome reports, and patient listings are on the left side of the Reports Tab. These preformatted reports require few or no additional selections from the user once the report is selected. Select the report title to open the report.

Reports in the Impairments and Medical Complications section contain no intermediary filters. For reports in the Cumulative reports and Patient Listings, the application will provide the required or optional parameters, such as start date and end date.

For the filtered reports, a report filters page displays first. This provides the user with an option of filtering these reports. Filters allow the selection of specific portions of the population to be included in the report while excluding all others. Refer to the section [Filtered Reports](#) in this manual.

The Cumulative, Patient Listing(s), Filtered, and Custom Reports may be converted to one of two formats:

Comma Separated Values (CSV)

Excel

Select the format after the Export Options label by clicking on either CSV or Excel.



Custom Reports

Custom reports for the SCIDO population can be created using the Report Designer, located on the right side of the Reports Tab. The Report Designer allows the user to select the criteria, format, and information needed for a report. Custom reports output displays all applicable records within the filter criteria.

To generate a custom report, first select a category and subject area of information to use in the report. Then select specific attributes to print in the report or to use as filters or sorting criteria. Sorting determines the order in which the rows of information occur. Filters allow the selection of specific portions of the population to be included in the report while excluding all others.

For more information, refer to the section in this manual called [Custom Reports](#).

Impairments and Medical Complications Reports

The following Impairments and Medical Complications reports provide information regarding diagnoses, procedures, treatments, medications, laboratory results, radiological findings, and outcomes that pertain to a specific health condition, status, or concern:

Influenza Diagnoses and Treatment

Influenza Immunizations

Pain Assessment and Treatment

Pneumococcal Immunizations

Pneumonia and Respiratory

Pressure Ulcer Report

Urinary Tract Infections

After the user has selected a date range for a report, information regarding the above topics is displayed from other VistA applications. This information is display-only. The default is five years if another date range is not selected.

Two of the reports in the Impairments and Medical Complications section of the Tab provide summary information for Veterans with SCI&D from the Resident Assessment Instrument–Minimum Data Set (RAI-MDS):

- RAI-MDS Quality Indicators Report
- RAI-MDS Resource Utilization Groups

The RAI-MDS is used in all VA Community Living Centers (CLC) and VA Spinal Cord Injury (SCI) Units surveyed under the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Long-Term Care (LTC) standards. The standardized RAI-MDS has been shown to contribute to improvement of care quality, nursing record documentation, and in resident cooperation and engagement.

The **RAI-MDS Quality Indicators** Report provides information for a specific patient on twenty-five quality indicators derived from the Resident Assessment Instrument–Minimum Data Set (RAI-MDS). The default date for this report is the previous month. The user can also select a different month from the dropdown for a report. Information regarding these twenty-five quality indicators is displayed if the patient is in a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Long-Term Care (LTC) setting in the VA. Even though information may not be available for the specific patient, summary information regarding these twenty-five quality indicators at both the regional and national levels will be provided.

The **RAI-MDS Resource Utilization Groups (RUG)** Report provides information about resource utilization groups, assessment activities of daily living, and RUG case mix index weights for all Veterans at the SCI regional level. This information will be provided for Veterans with SCI in JCAHO Long-Term Care Settings in the VA.

Cumulative Reports

Cumulative Reports produce statistical reports of Outcomes information across diagnostic categories, based on user-selected range of care end dates. A definition of each row displayed in the reports is provided in [Appendix D](#).

- Annual Evaluation Outcomes Report
- Continuum of Care Inpatient Outcomes
- Inpatient Rehabilitation Outcomes
- Outpatient Rehabilitation Outcomes

Patient Listing(s) Reports

The following Patient Listing(s) Reports provide summary displays of information about patients either at your medical center or throughout the SCI region depending on the settings chosen on the Administration page when setting up the application. Some reports, such as the Inpatient/Outpatient Report and Inpatient/Outpatient Specific report, may have slow response times.

Admissions (SCI&D) Report provides a list of SCI&D patients who have been admitted within a user-specified date range. The list consists of admitted patients who are either in the SCIDO application or who have been marked as SCI in the Patient file (i.e., field 57.4, "SPINAL CORD INJURY"). This option is useful in highlighting patient records that are not yet in the SCIDO application.

The **Applications for Inpatient Care** Report produces a report on applications for inpatient care during a specific range of dates.

The **Community Discharges** Report provides a list of SCI&D patients who have been discharged within a user-specified date range and discharge destinations. A discharge to independent living (community discharge) rate is also calculated.

The **Discharges (SCI&D)** Report produces reports on discharged patients for a user-selected date range displaying discharge dates, discharge location, diagnosis codes, and other information.

The **ICD Code Search** Report allows users to find patients in or out of the SCIDO application who have one particular ICD code, have several ICD codes, or fall within a range of ICD codes. The report searches the patients in the inpatient PTF file (#45) according to user-specified admission dates and will include patients who have any of the specified inpatient ICD codes. This report has a 90 limit maximum for ICD Code items.

The **Patient Education** Report provides a list of SCI&D patients who have a date of onset within a user-specified date range and a user-selected date range of educational sessions. This report displays their completion of sixteen educational modules and calculates completion rates for sixteen educational topics.

The **Patient Summary** Report provides basic registration information for either one patient or all SCI&D patients. The value that displays in the SCI Level column corresponds to the ASIA Neuro Level. The value that displays in the Extent of SCI column corresponds to Complete or Incomplete from ASIA.

The **Readmissions Report** displays a list of SCI&D patients based on user-selected date range of discharge dates. The number of readmissions to a VA Medical Center within thirty days of discharge from an index hospitalization is displayed by medical center division and ward at time of discharge.

Filtered Reports

Filtered reports allow the selection of specific portions of the population for review before the reports are generated.

Filters are used to include only certain types of data in a report while excluding others. For example, the user can restrict a report to only persons who are over the age of 65 and are $\geq 70\%$ Service - Connected. No filtering is performed if a value is not selected for a filter. Filtered reports include:

Basic Patient Information Report displays the patient's Name, Social Security Number (SSN), Date of Birth, Telephone Number, Street Address 1, Street Address 2, City, State, and ZIP Code.

Breakdown of Patients Report uses demographic categories to summarize characteristics of a caseload of Veterans. This report may be limited to a specific time interval in addition to all the standard filter options.

Current Inpatients Report displays those patients in the SCIDO application who currently have an inpatient status. This report displays the patient's Name, Last Four of the SSN, Ward, Admission Date, Current Length of Stay, Fiscal Year to Date Length of Stay, Admission Diagnosis, Patient's Room and Bed.

Expanded Patient Listing Report displays the Patient Name, SSN, Home Telephone, Network Status, Registration Status, Address (including county), Last AE Offered, Last AE Received, Eligibility, Primary Care VAMC, Provider, Neuro Level, Etiology, and Date of Onset.

Patients with Future Appointments Report displays patients having future clinic appointments within a user specified date range. The user may select SCI&D patients both from within and outside the application. The report displays the appointment date and time, Clinic Name, Patient Name, and Last Four Numbers of the SSN.

Follow-Up Last A.E. Received Report identifies patients who have not had an annual evaluation within a specified period of time. The user will be prompted to select a period of time.

Follow-Up (Last Seen) Report identifies patients who have not been seen for VA health care within a specified period of time. The user will be prompted to select a period of time.

Inpatient Outpatient Activity Report produces reports on inpatient stays and outpatient stops and visits over a specific range of dates.

NOTE: A "stop" is credited for each entry of a stop code. A "visit" is distributed among each stop credited on a given date. A single visit with two stop codes credited shows as 0.5 visits for each stop code. A total of 1.00 visits is given for outpatient activity on a given date. The "Number of highest users to identify" refers to the number of patients that were the most active that should be shown on the report.

Inpatient Outpatient Specific at Your Division Report displays information on patients who have used specific inpatient or outpatient resources. For outpatient activity, the option indicates the number of visits to the clinic STOP CODE(s) specified during the indicated time period. The number of stays and length of stay within a specific Specialty indicate inpatient activity. The user can select a date range, specific clinics, specific bed sections, and select clinics and statistics and/or patient usage data.

Laboratory Utilization at Your Division Report summarizes laboratory use by patients in the application over a selected date range.

Lab Utilization (Specific) at Your Division Report produces specific laboratory utilization displays for patients in the application. The user is prompted to enter a Range of Dates, Laboratory Test Names (can select up to 20 laboratory test names), and select specific laboratory tests and statistics and/or patient usage data.

Mailing Labels Report produces information to produce mailing labels for patients in the application. Mailing label information may be downloaded into an electronic spreadsheet that could be used with mail merge functionality to produce formatted labels for specific mailing label products.

MS (Kurtzke) Measures Report displays MS (Kurtzke) Functional System Scale Scores (FSS) and Expanded Disability Summary Scale Scores (EDSS) for selected patients. It also displays patient date of birth (DOB) and social security number (SSN).

New SCI&D Patients Report lists SCI&D patients who have a recent registration date within a user-selected registration date range. The report displays the patient's Registration Date, Name, SSN, Etiology, and VA SCI Status in the Patient File.

Patient Listing Report displays Patient Name, SSN, Date of Birth, Eligibility, Means Test, Neurological Level, Primary Care Provider, AE Received, AE Next Due Etiology, and Date of Onset

Patient Listing by State and County Report provides basic patient information sorted by county and state. Information displayed includes state, county, patient name, social security number, date of birth, eligibility, means, neurological level, primary care provider, annual evaluation received date, annual evaluation next due date, etiology, and date of onset.

Pharmacy Utilization at Your Division Report displays use of pharmacy medications and some supplies for patients in the application. A user-selected date range, minimum number of fills to display, minimum dollar cost of dispensed fills to display, the highest number of users to identify, and the method for computing dollar costs are options for defining report parameters.

NOTE: the output may contain other medications in the report output if other fills are attached to the patients within the time frame regardless of the medications selected on the filters page. If the user wants to see only specific drugs in the report, the user must run the Pharmacy Utilization (Specific) report.

Pharmacy Utilization (Specific) at Your Division Report displays use of a specific generic medication name for patients in the application and displays the dollar cost of prescriptions. The user

is prompted to enter a range of dates, select a generic drug name (can select up to 20 generic drug names), and select specific medication fills and statistics and/or patient usage data.

Prosthetics Utilization at Your Division Report displays use of prosthetic devices and sensory aids for patients in the application. A user-selected date range can be specified for generating the report.

Prosthetics Utilization (Specific) at Your Division Report displays use of a specific prosthetic device or sensory aid for patients in your SCIDO application and displays the dollar cost of these items. The user is prompted to enter a range of dates and select a prosthetic item, multiple items, or a range of items (can select up to 20 prosthetic items).

The Radiology Utilization at Your Division Report has multiple sections showing the various completed radiology procedures and their associated costs (if the cost data is present) during the user-selected date range. Minimum number of procedures, minimum dollar cost of procedures, and highest number of users to identify are also user-selected parameters for the report.

Report Filters

The Report Filters page is used to select criteria for reports. After launching a filtered report from the middle Filtered Reports section of the Reports page, the Report Filters page displays.

Patient Search		Spinal Cord Injury and Disorders Outcomes				Logout
Name: SPINALCORD,SIXTEEN SSN : 000-00-0016		Date of Birth : 03/04/1933 (73 yrs.) Education: PR		Neuro. Level: C06 Employment: UU		ASIA: C Bladder Drainage: SC Next AE Due: 01/17/2007 Pressure Ulcer: 3
Report Filters						
Additional Care VA	13TH & MISSION DOM (662BU) ABERDEEN (438GD)		Inpatient Visit	Start Date: [] to End Date: []		
Age	Youngest: [] to Oldest: []		Medications [Under Construction]	0081-0359-90 5-HYDROXYTRYPTOPHAN ABACAVIR300/LAMIVUDINE150/ZDV 300MG TAB		
Annual Evaluation Next Due	Start Date: [] to End Date: []		Outpatient Visits [Under Construction]	ACTIVE DUTY SEX TRAUMA - 524 ADMIN PAT ACTIVITIES (MASNONCT) - 674 ADMITTING/SCREENING - 102		
Annual Evaluation VA	13TH & MISSION DOM (662BU) ABERDEEN (438GD)		Primary Care VA	13TH & MISSION DOM (662BU) ABERDEEN (438GD)		
Asia Impairment	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> Unknown		Prosthetics [Under Construction]	ADDITION TO LOWER EXTREMITY, LIMITED ANKLE MO ALL LOWER EXTREMITY PROSTHESES, MULTIAXIAL ANKLE/FOOT MULTI-DUROMETER SYMES		
Asia Neuro Level	Top Neuro. Level: [] to Lowest Neuro. Level: []		Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown or Refused		
Category of Injury	<input type="radio"/> Tetraplegia <input type="radio"/> Paraplegia		Ethnicity	<input type="radio"/> Hispanic or Latino <input type="radio"/> Unknown <input type="radio"/> Not Hispanic or Latino		
Cause of Injury	<input type="radio"/> Traumatic <input type="radio"/> Non-Traumatic		Registration Status	<input type="checkbox"/> Not SCD <input type="checkbox"/> SCD-Not Currently Served <input type="checkbox"/> SCD-Currently Served <input type="checkbox"/> Expired		
County	State: [] County: []		SCI Network	<input type="radio"/> Yes <input type="radio"/> No		
Division	13TH & MISSION DOM (662BU) ABERDEEN (438GD)		Service Connection	% Start Value: [] % End value: []		
Etiology	TFA = Fall TSA = Sports Activity TVE = Vehicular TVI = Violence		Sex	<input type="radio"/> Male <input type="radio"/> Female		
Fee Basis	Start Date: [] to End Date: []		Total FIM Change	Smallest Change: [] Start Date: [] Largest Change: [] to End Date: []		
Geographic Area	Start Zip Code: [] To End Zip Code: []		Vital Status	<input type="radio"/> Alive <input type="radio"/> Dead		
Hours of Help Needed	Low Value: [] Start Date: [] High Value: [] to End Date: []		Walk/Wheelchair	<input type="radio"/> Walk <input type="radio"/> Wheelchair <input type="radio"/> Both Start Date: [] to End Date: []		
<input type="button" value="Back"/> <input type="button" value="Print"/> <input type="button" value="Reset"/> <input type="button" value="Submit"/>						

For filters with a dropdown, such as Primary Care VA, enter the first letter, and the system will go to that alphabetical section. If a filter can have more than one criterion, to select more than one criterion at one time, hold down the Ctrl Key and highlight all desired criteria. To select a range of criteria, select the first criterion, hold down the Shift key, and make the final selection.

NOTE: The filter parameters selected on the Filters Page are displayed following the data in the report output.

The following filters are available:

Additional Care VA – Select the facility and facility number from the dropdown. Enter the first letter of the facility and the system will go to that alphabetical section.

Age
Youngest
to Oldest

Annual Evaluation Next Due
Start Date
to End Date

Annual Evaluation VA – Select the facility and facility number from the dropdown. Enter the first letter of the facility and the system will go to that alphabetical section.

ASIA Impairment - multiple selections are allowed. The ASIA Impairment Scale is filtered based on most recent Non-Goal ASIA.

A
B
C
D
E
Unknown

ASIA Neurological Level. The ASIA Neurological Level is filtered based on most recent Non-Goal ASIA.

Top Neuro. Level
to Lowest Neuro. Level

Category of Injury

Tetraplegia

This filter selection returns records with Computed ASIA Neurologic Level is equal to C01, C02, C03, C04, C05, C06, C07, or C08

Paraplegia

This filter selection returns records with Computed ASIA Neurologic Level equal to T01, T02, T03, T04, T05, T06, T07, T08, T09, T10, T11, T12, L01, L02, L03, L04, L05, S01, S02, S03, S04, or S05.

Cause of Injury

Traumatic
Non-Traumatic

County

State
County

Division – Select the division from the dropdown. Enter the first letter of the division and the system will go to that alphabetical section.

Etiology – Multiple selections are allowed. Select the etiology from the following:

TFA = Fall
TSA = Sports Activity
TVE = Vehicular

TVI = Violence
TOT = Other (Traumatic)
TUN = Unknown (Traumatic)
NAD = Arthritic Disease or Cervical Stenosis
NIA = Infection or Abscess
NMN = Motor Neuron Disease
NMS = Multiple Sclerosis
NPM = Poliomyelitis
NSY = Syringomyelia
NTU = Tumor
NOT = Other (Non-Traumatic)
NUN = Unknown (Non-Traumatic)
NTV = Vascular

Fee Basis

Start Date
to End Date

Geographic Area

Start Zip Code (Five Digits)
to End Zip Code (Five Digits)

Hours of Help Needed (from the CHART-SF)

Low Value to High Value
Start Date to End Date

Inpatient Visit

Start Date
to End Date

Medications (Under Construction) – Select the medications from the dropdown. Enter the first letter of the medication, and the system will go to that alphabetical section.

Start Date
to End Date

Outpatient Visit (Under Construction) – Select the Outpatient Clinic(s) from the dropdown. Enter the first letter of the clinic name, and the system will go to that alphabetical section.

Start Date
to End Date

Primary Care VA – Select the facility and facility number from the dropdown. Enter the first letter of the facility, and the system will go to that alphabetical section.

Prosthetics (Under Construction) – Select the prosthetics item(s) from the dropdown. Enter the first letter of the prosthetic item, and the system will go to that alphabetical section (CPT code and or Description).

Race – Multiple selections are allowed from the following:

American Indian or Alaskan Native
Asian
Black or African American
Hispanic or Latino
Native Hawaiian or Pacific Islander
White

Unknown or Refused

Ethnicity

Hispanic or Latino

Not Hispanic or Latino

Unknown

Registration Status – Multiple selections are allowed

Not SCD

SCD – Currently Served

SCD – Not Currently Served

Expired

SCI Network

Yes

No

Service Connection

% Start Value

% End Value

Sex

Male

Female

Total FIM Change

Smallest Change

Largest Change

Start Date

To End Date

Vital Status

Alive

Dead

Walk/Wheelchair (Under Construction) – Select one button from Walk, Wheelchair, or Both.

Start Date

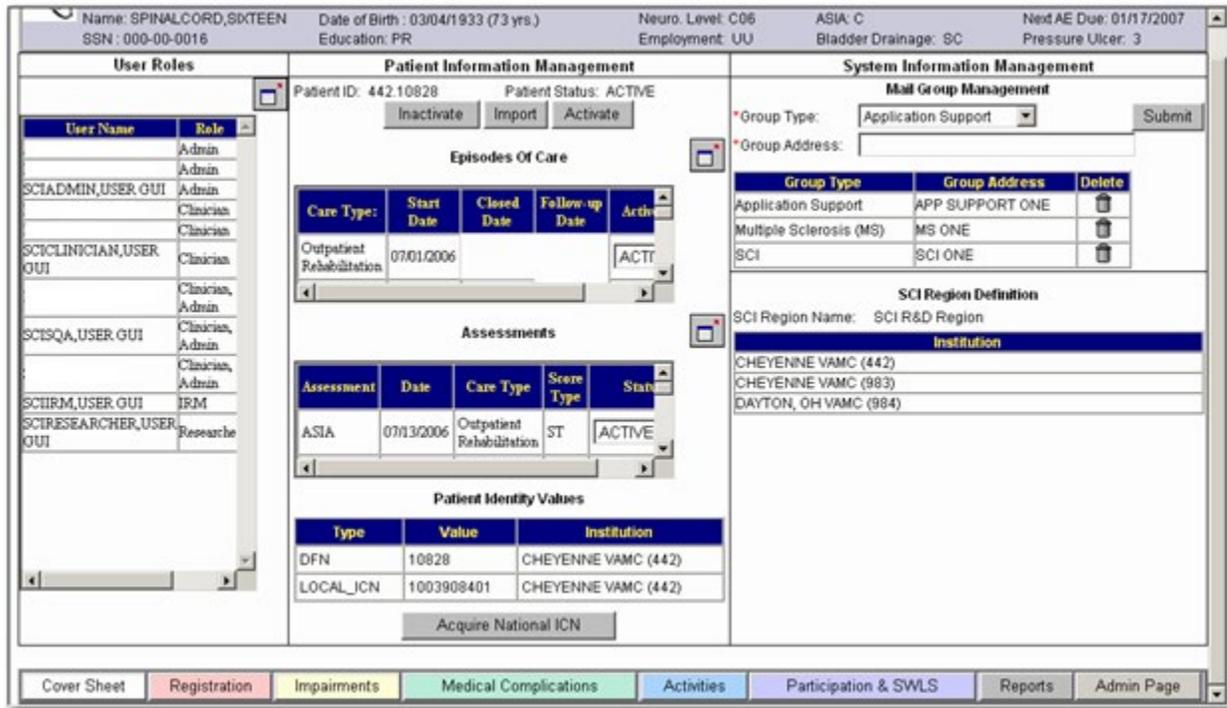
to End Date

Administration and Information Resource Management

Administration Tab

The Administration Page provides the functionality to

- View user roles and record access permissions
- Activate or inactivate patient status
- Import patient records from the national database
- Activate or inactive Episodes of Care
- Activate or inactivate patient assessments
- View patient identity values and acquire a national Integration Control Number (ICN)
- Add or delete SCI, Multiple Sclerosis (MS), and application support mail groups
- View medical centers in SCI regions (also known as catchments)



NOTE: In order to access the Administration Page, the user must be assigned the role of Administrator. Users may have roles of clinician, administrator, or researcher. Another role of IRM is for an information resource management role, described in the IRM section. When a user with an administrator role accesses the application, an additional tab labeled Admin is located in the footer of the application to permit access to Administrator functions.

User Roles and Record Access

The application displays user roles and system access to records for either the local institution or the entire SCI region. User roles and system access are defined in VistA. Roles and access are assigned through VistA File 200, the “New Person” File. The Automated Data Processing Applications

Coordinator (ADPAC) can modify the user’s SCIDO profile in VistA File 200. The ADPAC will need to know whether the user has the role of a clinician, administrator, or researcher. Most SCI Coordinators at SCI Primary Care Teams need to be assigned the role of administrator (which includes the capabilities of the Clinician role). Research access is limited to those who have an approved VA research project and approval from an Institutional Review Board (IRB).

Regional or Institutional View

The user can request from an ADPAC either an institutional or regional view of information. An institutional view is recommended to improve response time. Users should note that access to the SCI region may provide a more comprehensive view of patient status and the SCI&D population. However, response times may be slower. An institutional view is recommended for most clinicians.

User Roles

The application allows a user to access the application and to work within an assigned area of the application. Valid roles are Clinician, Administrator, Researcher, and IRM.

Role	Access
Clinician	Clinicians who have clinical privileges to create, modify, display, store, and sign patient information into the computerized patient record system (CPRS).
Administrator	Individuals who have SCIDO application management permissions for identifying mail groups and deleting records (SCIDO Coordinators, CACs, ADPACs, etc.). The administrator role includes Clinician role capabilities.
Researcher	<p>Researchers are provided limited access to aggregate patient data only (national access only).</p> <p>Researchers are allowed to query and generate reports from the national SCIDO database after they have documented they have an approved VA research project, approval from an Institutional Review Board, and an approved Data Transfer and Data Use Agreement from VHA Patient Care Services.</p>
IRM	The Information Resource Management (IRM) role allows modification of the SCIDO application, such as being able to add or delete medical centers from SCI regions, modify regional attributes, perform database seeding, perform a national or regional audit, and monitor system activity.

SCI Region List of Institutions

SCI regions (also known as catchments) include SCI centers and associated SCI primary care team facilities. Institutions belonging to the SCI region are displayed by Number and Name. A user with Admin permission can view the medical centers within their region, but only the IRM can add or delete medical centers from the SCI Region list on the IRM page. Refer to the section on the IRM tab.

Import Patient Records

A SCIDO Administrator may import patient records from the national database. This function is useful for patients who relocate to or from an area. The patient’s records may not be available at the current location, so the Administrator is asked to import their records. This function imports all SCIDO records for a patient.

Import Patient Records

Before this procedure starts, you have already navigated to the correct patient record and the Admin Tab page.

1. The patient ID and Patient Status (Active or Inactive) is displayed in the Patient Information Management section of the Admin page.
2. Select the *Import* button to import the patient's records from the national database.
3. A message is displayed asking if you are sure you want to import the current patient from the national SCIDO database. The system displays OK and Cancel options.
4. Select the *OK* button to continue the import process.
5. If the system matches at least one record to the SSN, a window labeled "Import Patient from National SCIDO Registry" displays the Patient Name, SSN, Institution, Status, and Date of last Review.

Select	Patient Name	SSN	Institution	Status	Date of Last Review
<input type="radio"/>	SPINALCORD,NINE	000000009	CHEYENNE VAMC (442)	ACTIVE	07/17/2006

6. Select the button in the Select column by the patient name whose records you want to import and select the *Submit* button to request the import process for this patient's records to continue.
7. The system displays a message "The local SCIDO has been updated with the selected patient's information."
8. Select the *OK* button.

Activate or Inactivate a Patient's Status

A SCIDO Administrator may activate or inactivate a patient's status locally. This function is used for patients who relocate to or from the SCI region. Activation of a Veteran's status indicates a non-deleted status. When a Veteran's status is inactivated, medical information for the Veteran will not be displayed or included in SCIDO application reports for that institution.

Activate a Patient within the SCI institution

Before this procedure starts, you have already navigated to the correct patient record and the Admin Tab page.

1. The application displays the Administration page with the patient's ID and Patient Status displayed in the Patient Information Management section.
2. Select the *Activate* button.
3. The system asks, "Are sure you want to activate the current patient?"
4. Select the OK option.
5. The patient's status is displayed as "Active."

Inactivate a Patient within the SCI Institution

Before this procedure starts, you have already navigated to the correct patient record and the Admin Tab page.

1. The Administration page with the patient’s ID and Patient Status displayed in the Patient Information Management section.
2. Select the *Inactivate* button.
3. The system asks, “Are sure you want to inactivate the current patient?”
4. Select the OK option.
5. The patient’s status is displayed as “Inactive.”

Activate or Inactivate Episodes of Care

A SCIDO Administrator may cautiously activate or inactivate a patient’s episodes of care. This can be useful when records are initially migrated or after patients imported records have time conflicts between records. Activation or inactivation of episodes of care should be done with great caution as problems can be created for assessments.

When an episode of care is inactive, it will no longer be displayed on the Episodes of Care Management page. To active or inactive an episode of care, select the Window Expander icon, and a new window is displayed with a list of episodes of care for the patient. Select the Active or Inactive from the dropdown by the episode of care and select the *Submit* button to submit the information.

The SCIDO system prevents activating overlapping EOCs by displaying the following message: “Episode of Care overlap detected. Changes were not saved.”

Activate or Inactivate Assessments

A SCIDO Administrator may activate or inactivate a patient’s assessments within an SCI facility. Inactivation is used to inactivate erroneous records that cannot be appropriately modified through the assessment editing process.

To activate or inactivate an assessment, select the Window Expander icon  next to the Assessments field, and a new Window opens with a list of assessments for the patient:

Assessment History				
Assessment	Date	Care Type	Score Type	Status
ASIA	01/17/2006	Outpatient Rehabilitation	ST	ACTIVE ▾
AUDIT	04/01/2004	Annual Evaluation	UN	ACTIVE ▾
CAGE	01/17/2006	Outpatient Rehabilitation	ST	ACTIVE ▾

Select the *Active* or *Inactive* from the dropdown by the assessment and select the *Submit* button to submit the information.

The system displays all assessment summary information for the selected patient as contained in the local SCIDO, sorted alphabetically with the ASIA first in Record Date order from the most recent to the most remote.

Acquire National Integration Control Number (ICN)

The Administrator selects the *Acquire National ICN* button to acquire an Integration Control Number (ICN) from the Master Patient Index (MPI) Service for the selected patient at the national level. After this

option is selected and the *OK* button selected, the System displays a message: “A request has been sent to the Master Patient Index (MPI) to assign a National ICN. Check back in a few minutes to see if it has been assigned.”

The System sends a query to MPI for a national ICN, which will be used to link patients to their records across VHA systems, the Master Patient Index (MPI/PD) at the national database, and across regions within SCIDO. The system will display the national ICN after a few minutes in the Patient Identity Values section as a Type, which is a GLOBAL_ICN. The Value is a unique number in MPI. The institution is the institution that the Administrator is logged into and at which the patient is registered.

Patient Identity Values		
Type	Value	Institution
DFN	14075	CHEYENNE VAMC (442)
LOCAL_ICN	1003898509	CHEYENNE VAMC (442)

Acquire National ICN

Establish or Remove Mail Groups

A SCIDO Administrator can modify, add, or delete mail groups. If a site wants to be able to notify a specific group when patients with SCI or MS are admitted or discharged, VistA mail groups can be created for that purpose. Only the names of VistA mail groups should be entered since other e-mail systems are not HIPAA or Privacy Act compliant. There are three types of e-mail groups that can be entered: SCI Notification Mail Group(s), MS Notification Mail Group(s), and SCIDO Application Support Group(s).

Mail Group Management		
*Group Type:	Application Support	Submit
*Group Address:	<input type="text"/>	
Group Type	Group Address	Delete
Application Support	APP SUPPORT ONE	
Multiple Sclerosis (MS)	MS ONE	
SCI	SCI ONE	

Mail Group Management Section of the Administration Page

To add an SCI mail group, select the group type from the dropdown, enter the group address, and select the *Submit* button. The group address must be entered correctly since no matching or global directory functionality exists. The same process is done to add a Multiple Sclerosis (MS) or Application Support mail group.

To remove a mail group, select the Trashcan icon in the Delete column for that mail group.

SCI Region Definition

The SCI Region Definition section displays the SCI Region name and a list of the institutions (by name and number) that belong to that region. This information can only be viewed. Refer to the Information Resource Management (IRM) section for information on how SCI regions are defined.

SCI Region Definition	
SCI Region Name:	SCI R&D Region
	Institution
	CHEYENNE VAMC (442)
	CHEYENNE VAMC (983)
	DAYTON, OH VAMC (984)

Information Resource Management (IRM) Page

The Information Resource Management (IRM) tab allows a user with the IRM role to modify regional attributes, add or delete medical centers from their SCI region, perform a national or regional update, and monitor system activity. This section provides a brief description of the IRM capabilities.

The functionality exists on this page to update the region based on data for the specific region in the National Repository or to update the National Repository based on data for the specific region held in the local repository.

WARNING: a reverse seeding has the potential to overwrite data at the National level and this action should be coordinated.

Spinal Cord Injury & Disorders Outcomes IRM Area
Logout

Regional Attributes

Region Name:

Regional DS Endpoint:

National DS Endpoint:

MPI Application Name:

Database Version:

Regional Institutions

Institution:

Connector JNDI Name:

DUZ Code:

Institution	Connector JNDI Name	DUZ Code	Delete?
PUGET SOUND HCS (663)	vlij/sci_663		
WHITE CITY VAMC (692)	vlij/sci_692		
ALASKA VAHSRO (463)	vlij/sci_463		
MONTANA HCS (436)	vlij/sci_436		
SPOKANE VAMC (668)	vlij/sci_668		

Regional Attributes

IRM/ISS/ITC staff may modify the SCI region by specifying regional and national endpoints, the MPI Application Name, and Database Version. Great care should be exercised in modifying these parameters since it is likely to have profound effects on the functionality of the SCIDO application and regional versus institutional views of information for the users.

Regional Institutions

SCI Regions (also known as catchments) include SCI centers and associated SCI primary care team facilities. Institutions belonging to the SCI region are displayed by Number and Name. Only an IRM can add or delete medical centers from the SCI Region list.

Monitor System Activity

An IRM may monitor system activities, which include the following:

- Record locks
- Audit log report (list of persons who have entered or edited information within the application)

Record Locks

IRM/ISS/ITC staff can view details about the system, such as which patient records are being viewed by users, and which user has Assessment or Episode of Care (EoC) locks on patients' records by selecting the *Locking Detail* button. In the example shown below, a user (USER Gui SCIClinician) is adding an assessment for the patient SPINALCORD, NINETEEN, so a record lock is created so that other users may not add assessments for that patient as long as another assessment is in the process of being created.

SCI WEB Locking and Patient Use Detail						
Patients in Use		EOC Locks		Assessment Locks		
User Name	Patient Name (# observers)	User Name	Patient Name	Lock Date/Time	User Name	Patient Name
User Gui SCIClinician	SPINALCORD,NINETEEN(1)				User Gui SCIClinician	SPINALCORD,NINETEEN 06/09/2006 15:22:51
User Gui SCIClinician	SPINAL,CORD PTONE(1)					
User Gui Sciadmin	SPINALCORD,FIVE(1)					
User Gui SCIClinician	SPINALCORD,TWENTY(1)					

Audit Log Report

The Audit Log Report allows IT staff to report information about the SCIDO system at the local division. IT staff can create reports to display user data, such as how many assessments have been created and who has entered or modified an assessment for a particular patient or for all patients during any time period. For example, it can determine by date and time, which users logged in to or out of the system.

Audit Log Report

Begin Date: Time:

End Date: Time:

Patient ID:

User ID:

Action:

Subject:

Please complete the above report parameters and click the Submit button to display the report

National/Regional Update

IT staff can synchronize data between the regional database and the national database by using the *National/Region Update* button. IT staff can choose to either update the regional database based on data for this region in the national database or update the national database with information from the regional database.

NOTE: A valid email address must be entered for completion of notification. Entering an invalid address will cause the system to notify the user that the format is invalid.

Choose Operation to Perform

Update Region based on data for this Region in the National Repository

Update National Repository based on data for this Region held in the local repository

* Email Address: for completion notification

Appendix A: Definitions and Acronyms

Definitions

Term	Definition
Assessment	An instrument, measure, or other survey in the SCIDO application, such as the CHART-SF or the ASIA, after it has been completed and contains patient data
Audit Trail	A history of the changes made to a record including the name of the user who made the change
Division	A subunit of the institution list.
Institution	A hospital with or without subdivisions.
Instrument	A measurement form or questionnaire that is used to evaluate a patient's impairments, medical complications, activities, participation, or satisfaction with life. The instrument does not contain data, but is used to capture data specifically related to one patient at a specified point in time
MH Assistant	Mental Health Assistant
Outcomes	Documented results or changes in patient's performance and conditions in relation to the interventions or services used
Thin-client	A simple client program, which relies on most of the function of the system being in the server, usually the Web browser in a Web domain
User	An Administrator, a Clinician, or a Researcher who uses the application
VistA	Veterans Health Information System and Technology Architecture
VistA MailMan	VistA's electronic mail system

Acronyms

Acronym	Definition
ADPAC	Automated Data Processing Application Coordinator
ASIA	American Spinal Injury Association
AUDIT	Alcohol Use Disorders Identification Test
BMI	Body Mass Index
CAGE	Brief alcohol disorder assessment instrument (CAGE is not an acronym)
CARF	Rehabilitation Accreditation Commission previously known as Commission on the Accreditation of Rehabilitation Facilities
CES-D	Center for Epidemiologic Studies Depression Scale
CHART-SF	Craig Handicap Assessment and Reporting Technique – Short Form
CCOW	Clinical Context Object Workgroup
CCR	Computerized Clinical Reminder
CPRS	Computerized Patient Record System
CPT	Current Procedural Terminology
VS	Vital Signs
DAST	Drug Abuse Screening Test
DBIA	Database Integration Agreement
DUSOI	Duke Severity of Illness
DUSOI-A	Duke Severity of Illness Analog Scale, an instrument that is faster to complete than the DUSOI, but provides fewer details
FAM	Functional Assessment Measure
FIM	Functional Independence Measure
GUI	Graphical User Interface
HCPCS	Healthcare Common Procedure Coding System
HL7	Health Level Seven (standard for electronic data exchange/messaging protocol)
HSD&D	Health Systems Design and Development
HTTP	HyperText Transfer Protocol
HTTPS	HyperText Transfer Protocol Secure
ICN	Integration Control Number
IE	Internet Explorer
IEN	Internal Entry Number
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
Kurtzke EDSS	Kurtzke Expanded Disability Status Scale (used for Multiple Sclerosis)
Kurtzke FSS	Kurtzke Functional Systems Scale (used for Multiple Sclerosis)
LOINC	Logical Observation Identifiers, Names, and Codes
MNFM	Medical Needs and Function Modifiers
NOIS	National Online Information System

Acronym	Definition
PCE	Patient Care Encounter
PIMS	Patient Information Management System
PRIME-MD	Primary Care Evaluation of Mental Disorders
PSL	Person Service Lookup
PTF	Patient Treatment File
PUSH	Pressure Ulcer Scale for Healing
SCD Registry	Spinal Cord Dysfunction Registry
SCI&D	Spinal Cord Injury and Disorders
SCIDO	Spinal Cord Injury and Disorders Outcomes Application
SF-8	SF-8 Health Survey
SF-MPQ	Short Form McGill Pain Questionnaire
SRS	Software Requirements Specifications
SSO	Single Sign-On
SWLS	Satisfaction with Life Scale (Diener's)
TBI	Traumatic Brain Injury
TCP/IP	Transmission Control Protocol/Internet Protocol
TIU	Text Integration Utility
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Appendix B: Copyright Information

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AUDIT: Reproduced with permission from the World Health Organization. Copyright © World Health Organization, Geneva.

CAGE: In the public domain from JA Ewing, 'Detecting Alcoholism: The CAGE Questionnaire' JAMA 252: 1905-1907, 1984.

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Appendix C: Instruments and Forms

Appendix C provides information about SCIDO instruments (Assessment Entry Forms) and two patient information forms.

NOTE: All assessments that allow the user to edit or view history always displays the most recent assessment first in the History List

The following twenty instruments are described in this section:

[American Spinal Injury Association Standard Neurological Classification of Spinal Cord Injury \(ASIA\)](#)

[Alcohol Use Disorders Identification Test \(AUDIT\)](#)

[Body Mass Index \(BMI\)](#)

[CAGE](#)

[Center for Epidemiologic Studies Depression Scale \(CES-D\)](#)

[Craig Handicap Assessment and Reporting Technique Short Form \(CHART-SF\)](#)

[Check Your Health \(CYH\) and Secondary Conditions](#)

[Drug Abuse Screening Test \(DAST\)](#)

[Duke Severity of Illness \(DUSOI\) Checklist](#)

[Duke Severity of Illness Analog \(DUSOI-A\) Scale](#)

[Functional Assessment Measure \(FAM\)](#)

[Functional Independence Measure \(FIM\)](#)

[Kurtze Expanded Disability Status Scale \(EDSS\)](#)

[Kurtzke Functional Systems Scale \(FSS\)](#)

[Medical Needs Function Modifiers \(MNFM\)](#)

[PRIME-MD Depression Screening](#)

[Pressure Ulcer Scale for Healing \(PUSH\)](#)

[Satisfaction with Life Scale \(SWLS\) \(Diener's\)](#)

[SF-8 Health Survey](#)

[Short Form McGill Pain Questionnaire \(SF-MPQ\)](#)

The following two patient information forms are described in this section:

[Registration Ancillary Data Entry Form](#)

[Patient Education Form](#)

American Spinal Injury Association (ASIA)

The ASIA instrument is derived from the American Spinal Injury Association Standard Neurological Classification of Spinal Cord Injury. The ASIA uses the findings from the neurological examination to classify injury types into specific categories. These categories allow clinicians to identify and classify different injuries and degrees of spinal cord damage. The ASIA Spinal Cord Injury Classification approach is the internationally accepted standard for spinal cord injury classification and has been adopted by most major organizations associated with spinal cord injury. This has resulted in more consistent, worldwide terminology used to describe the findings in spinal cord injury.

Before completing an ASIA Classification, clinicians should have completed professional training regarding its use. ASIA has offered its Neurological Classification Teaching Package since 1994. Recently, the Neurological Standards Committee completed an extensive revision of the manual, and a new version is available.

The ASIA also provides a companion graphic that shows dermatomes. Dermatomes are characteristic areas of the body surface from which each nerve root receives sensory input. Each dermatome on the diagram corresponds to a neurological level on the ASIA form.

Refer to the Reference Manual for the International Standards for Neurological Classification of Spinal Cord Injury.

To launch the ASIA instrument, select the *ASIA* button in the Assessment Entry Forms area of the Impairments page.

For the ASIA instrument to be calculated and saved, the following fields, other than Record Date, Care Type, and Score Type, require values.

Neurological Level - four fields [Sensory (R), Sensory (L), Motor (R), Motor (L)]
Complete/Incomplete (Extent of Injury – Incomplete = Presence of any sensory or motor function in lowest sacral segment)
ASIA Impairment Scale field.

NOTE: However, if one or more of the Motor Key Muscle fields or Key Sensory Point fields have been completed, then completion of all these fields is required.

To enter data into any of the Motor Key Muscle fields or Key Sensory Point fields, complete all the remaining ASIA fields to submit the instrument

NOTE: The care types of Inpatient Rehabilitation, Outpatient Rehabilitation, or Continuum of Care - Inpatient are used if there is an Episode of Care associated with the assessment. Refer to the Episode of Care section of this manual for further information.

Many outcome reports, benchmarks, and other SCIDO information are dependent on an accurate ASIA classification. Therefore, it is strongly recommended that ASIA information be entered before other information in an Episode of Care.

Within the SCIDO application, the ASIA appears as follows:

American Spinal Injury Association (ASIA) Standard Neurological Classification of Spinal Cord Injury Form

Name: SPINALCORD,FOURTEEN * Record Date: 09/01/2005

Division: 442 Care Start Date:

* Care Type: * Score Type:

Score: 0 ASIA Impairment:

Neurological level:

MOTOR

	Key Muscles	
	R	L
C2		
C3		
C4		
C5	<input type="checkbox"/>	<input type="checkbox"/>
C6	<input type="checkbox"/>	<input type="checkbox"/>
C7	<input type="checkbox"/>	<input type="checkbox"/>
C8	<input type="checkbox"/>	<input type="checkbox"/>
T1	<input type="checkbox"/>	<input type="checkbox"/>
T2		
T3		
T4		
T5		
T6		
T7		
T8		
T9		
T10		
T11		
T12		
L1		
L2	<input type="checkbox"/>	<input type="checkbox"/>
L3	<input type="checkbox"/>	<input type="checkbox"/>
L4	<input type="checkbox"/>	<input type="checkbox"/>
L5	<input type="checkbox"/>	<input type="checkbox"/>
S1	<input type="checkbox"/>	<input type="checkbox"/>
S2		
S3		
S4-5		

Voluntary anal contraction Yes No

SENSORY

Key Sensory Points

	Light Touch		Pin Prick	
	R	L	R	L
C2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
T12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
S4-5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any anal sensation Yes No

0 = total paralysis
 1 = palpable or visible contraction
 2 = active movement, gravity eliminated
 3 = active movement, against gravity
 4 = active movement, against some resistance
 5 = active movement, against full resistance
 NT = not testable

0 = absent
 1 = impaired
 2 = normal
 NT = not testable

0 + 0 = 0 PIN PRICK SCORE (max: 112)

0 + 0 = 0 LIGHT TOUCH SCORE (max: 112)

*** Neurological Level**
The most caudal segment with normal function

R	L
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

*** Complete or Incomplete?**
Incomplete = Presence of any sensory or motor function in lowest sacral segment

Complete Incomplete

Zone of Partial Preservation
Caudal extent of partially innervated segments

R	L
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

*** ASIA Impairment Scale**

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ASIA Instrument Fields

Neurological Level

For the Neurological Level field, the valid responses are as follow:

C01	=	Cervical 01	T08	=	Thoracic 08
C02	=	Cervical 02	T09	=	Thoracic 09
C03	=	Cervical 03	T10	=	Thoracic 10
C04	=	Cervical 04	T11	=	Thoracic 11
C05	=	Cervical 05	T12	=	Thoracic 12
C06	=	Cervical 06	L01	=	Lumbar 01
C07	=	Cervical 07	L02	=	Lumbar 02
C08	=	Cervical 08	L03	=	Lumbar 03
T01	=	Thoracic 01	L04	=	Lumbar 04
T02	=	Thoracic 02	L05	=	Lumbar 05
T03	=	Thoracic 03	S01	=	Sacral 01
T04	=	Thoracic 04	S02	=	Sacral 02
T05	=	Thoracic 05	S03	=	Sacral 03
T06	=	Thoracic 06	S04	=	Sacral 04
T07	=	Thoracic 07	S05	=	Sacral 05
UNK	=	Unknown			

Complete or Incomplete

Select Complete or Incomplete to denote any sensory or motor function detected in lowest sacral segment.

ASIA Impairment Scale

For the ASIA Impairment Scale, select one of the following options listed in the dropdown:

- A = Complete: No sensory or motor function is preserved in the sacral segments S4–S5.
- B = Incomplete: Sensory but not motor function is preserved below the neurological level and includes the sacral segments S4–S5.
- C = Incomplete: Motor function is preserved below the neurological level, and more than half of key muscles below the neurological level have a muscle grade greater than or equal to 3.
- D = Incomplete: Motor function is preserved below the neurological level, and at least half of key muscles below the neurological level have a muscle grade greater than or equal to 3.
- E = Normal: Sensory and motor functions are normal.
- UNK = Unknown.

After all mandatory information has been entered, select either the *Calculate* or *Submit* button. After selecting *Calculate*, the ASIA instrument calculates and provides the Neurological Level and ASIA Impairment score in the header of the instrument.

On the Impairments Tab in the ASIA Scores/Date (history) field, ASIA scores, record date, and score type are displayed for the most recent ASIA assessment. Select the ASIA Scores/Dates history dropdown to view a listing of the scores, record dates, and score types for all ASIA assessments. You can view (and edit) an individual ASIA assessment by selecting one of the assessment history lines

[For scoring information, refer to the ASIA Scoring Algorithm or to the ASIA Manual.]

Alcohol Use Disorders Identification Test (AUDIT) Instrument

The AUDIT instrument is derived from the World Health Organization’s Alcohol Use Disorders Identification Test and provides questions about a person’s alcohol use. The AUDIT was developed by the World Health Organization to identify persons whose alcohol consumption may become hazardous or harmful to their health. The AUDIT is a ten-item screening questionnaire with three questions on the amount and frequency of drinking, three questions on alcohol dependence, and four questions on problems caused by alcohol.

In most cases, a CAGE assessment is completed before the AUDIT. This allows a shorter screening process. Based on the CAGE score, the clinician may follow up with the AUDIT to gather more information about possible alcohol use and abuse. Refer to the [CAGE Instrument](#) section of this manual for more information.

The Alcohol Use Disorders Identification Test (AUDIT) assessment form may be accessed from the Assessment Entry Forms area of the Impairments tab.

Within the SCIDO application, the AUDIT appears as follows:

Alcohol Use Disorders Identification Test (AUDIT) Form

Name: SPINALCORD,SIXTEEN * Record Date:

Division: 442 Care Start Date:

* Care Type: Score Type:

Score:

* 1. How often do you have a drink containing alcohol?

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

3. How often do you have six or more drinks on one occasion?

4. How often during the past year have you found that you were not able to stop drinking once you had started?

5. How often during the past year have you failed to do what was normally expected of you because of drinking?

6. How often during the past year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

7. How often during the past year have you had a feeling of guilt or remorse after drinking?

8. How often during the past year have you been unable to remember what happened the night before because you had been drinking?

* 9. Have you or someone else been injured as a result of your drinking?

* 10. Has a relative or a friend or a doctor or other health worker been concerned about your drinking or suggested that you cut down?

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Select the most appropriate answer from the dropdown for each question. For the AUDIT instrument to be calculated and saved, the following fields, other than the header fields, require values.

Questions 1 through 10 (If the answer to Question 1 is Never, the evaluator can skip to Questions 9 and 10).

NOTE: The Care Types of Inpatient Rehabilitation, Outpatient Rehabilitation, or Continuum of Care - Inpatient are used if there is an Episode of Care associated with the assessment. Refer to the Episode of Care section of this manual for further information.

AUDIT Form Scoring

If the AUDIT Total Score is 8 or more, then the following is displayed:

“A score of 8 or more indicates a strong likelihood of hazardous or harmful alcohol consumption. Please consider referral to available resources for further evaluation or intervention. Brief intervention can work. Linking patients immediately to services can be successful.”

Refer to the Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care manual.

The score, record date, and score type for the most recent AUDIT is displayed on the Impairments tab in the Score/Dates (history) field. To view a listing of all AUDIT assessments, select the history field dropdown. You can view (and edit) an individual AUDIT assessment by selecting one of the assessment history lines.

[For scoring information, refer to the AUDIT Scoring Algorithm.]

Body Mass Index (BMI) Instrument

The Body Mass Index (BMI) instrument calculates a Body Mass Index as a measure of body fat based on height and weight that applies to both adult men and women.

The BMI instrument is accessible from the Impairments Tab and appears as follows:

The screenshot shows a web-based form titled "Body Mass Index (BMI) Form". The form is divided into several sections. The top section contains fields for "Name" (SPINALCORD,SIXTEEN), "Record Date" (12/18/2006), "Division" (442), "Care Type" (Outpatient Rehabilitation), "Care Start Date" (07/01/2006), and "Score Type" (a dropdown menu). Below this is a section for "Weight" (0.0 Pounds), "Height" (0.0 Inches), and "Body Mass Index" (0.0). At the bottom of the form are several buttons: "Back", "Print", "Blank Forms", "Cancel", "Reset", "Calculate", "Submit", and "Help".

Care Type and Score Type are not required for the BMI instrument. For the BMI instrument to be calculated and saved, the following fields, besides Record Date, require values.

Care Type and Score Type are not required for non-EOC assessments. However, if a Care type is entered on for either EOC or non-EOC BMI assessments, a Score type is required.

- Weight (Pounds or Kilograms)
- Height (Inches or Centimeters)

To use the BMI instrument, complete the following steps:

1. Enter the patient's weight in the Weight field and choose either pounds or kilograms from the dropdown.
2. Enter the patient's height in the Height text field, and choose either inches or centimeters (cm.) from the dropdown.
3. Select the *Calculate* button to calculate the patient's BMI.
4. The patient's BMI is displayed in the Body Mass Index field.
5. Select the *Submit* button to submit the Body Mass Index calculation.
6. The application returns to the Impairments Tab.

On the Impairments Tab, the score, date, and score type are not required or optional because the most recent BMI are displayed in the Body Mass Index (BMI) History field. Select the dropdown to view a listing of the scores, record dates, and score types for all BMI assessments. You can view (and edit) an individual BMI assessment by selecting one of the BMI assessment history lines.

[For scoring information, refer to the BMI Scoring Algorithm.]

CAGE

The CAGE instrument is one of two instruments that may be used to screen for alcohol abuse. The CAGE screening questionnaire is short and simple to administer. The CAGE instrument is most often the first instrument used to screen for alcohol abuse. Based on the CAGE score, the Clinician may then use the AUDIT instrument to gather more information about possible alcohol use and abuse.

To launch the CAGE instrument, select the *CAGE* button in the Assessment Entry Forms area of the Impairments page. The CAGE appears as follows:

CAGE Form

Name: SPINALCORD,SIXTEEN * Record Date:

Division: 442

* Care Type: Care Start Date:

Score: 0 * Score Type:

During the past twelve months:

* 1. Have you ever felt you should cut down on your drinking? Yes No

* 2. Have people annoyed you by criticizing your drinking? Yes No

* 3. Have you ever felt bad or guilty about your drinking? Yes No

* 4. Have you had an eye opener first thing in the morning to steady nerves or get rid of a hangover? Yes No

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Back Print Blank Forms Cancel Reset Calculate Submit Help

NOTE: The Care Types of Inpatient Rehabilitation, Outpatient Rehabilitation, or Continuum of Care - Inpatient are used if there is an Episode of Care associated with the assessment. Refer to the Episode of Care section of this manual for further information.

For the CAGE instrument to be calculated and saved, all four questions must have responses. After all mandatory information has been entered, select either the *Calculate* or *Submit* button.

By selecting *Calculate*, the overall score is calculated and displayed in the header of the CAGE. By selecting *Submit*, if a patient's score is one or greater, the following message appears describing further action to be taken:

CAGE Information

The patient's score is one or greater. A total score of one or greater may be clinically significant. Please consider completing the Alcohol Use Disorder Identification Test (AUDIT) for more comprehensive screening. Consider referral to available resources for further evaluation or intervention. Brief intervention can work. Linking patients immediately to services can be successful.

OK AUDIT

Select *OK* to return to the Impairments page. Select *AUDIT* to create an AUDIT assessment for the patient. Refer to the [Alcohol Use Disorders Identification Test \(AUDIT\) Instrument](#) section of this manual for information on completing an AUDIT assessment.

On the Impairments Tab, the score, date, and score type for the most recent CAGE are displayed in the Scores/Dates (history) field. Select the dropdown to view a listing of the scores, record dates, and score types for all CAGE assessments. You can view (and edit) an individual CAGE assessment by selecting one of the assessment history lines.

[For scoring information, refer to the CAGE Scoring Algorithm.]

Center for Epidemiologic Studies Depression Scale (CES-D)

The Center for Epidemiologic Studies Depression Scale (CES-D) form is a short, self-reporting scale intended for measuring current depressive symptoms in the general population. It can be accessed from the Impairments Tab or from the PRIME-MD® information form.

It is suggested that the Clinician complete the CES-D form if there is one Yes reply on the PRIME-MD assessment form. It is strongly recommended that the Clinician complete the CES-D form if there are two Yes replies on the PRIME-MD assessment form.

The CES-D assessment form contains twenty statements describing how the patient might have felt, thought, or behaved during the past week. The form appears as follows:

Center for Epidemiologic Studies Depression Scale (CES-D) Form

Name: SPINALCORD,SIXTEEN	* Record Date: <input type="text"/>
Division: 442	Care Start Date: <input type="text"/>
* Care Type: <input type="text"/>	* Score Type: <input type="text"/>
Score: <input type="text" value="0"/>	

Below is a list of ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

During the past week:

* 1. I was bothered by things that usually don't bother me.	<input type="text"/>
* 2. I did not feel like eating; my appetite was poor.	<input type="text"/>
* 3. I felt that I could not shake off the blues even with help from my family or friends.	<input type="text"/>
* 4. I felt that I was just as good as other people.	<input type="text"/>
* 5. I had trouble keeping my mind on what I was doing.	<input type="text"/>
* 6. I felt depressed.	<input type="text"/>
* 7. I felt that everything I did was an effort.	<input type="text"/>
* 8. I felt hopeful about the future.	<input type="text"/>
* 9. I thought my life had been a failure.	<input type="text"/>
* 10. I felt fearful.	<input type="text"/>
* 11. My sleep was restless.	<input type="text"/>
* 12. I was happy.	<input type="text"/>
* 13. I talked less than usual.	<input type="text"/>
* 14. I felt lonely.	<input type="text"/>
* 15. People were unfriendly.	<input type="text"/>
* 16. I enjoyed life.	<input type="text"/>
* 17. I had crying spells.	<input type="text"/>
* 18. I felt sad.	<input type="text"/>
* 19. I felt that people disliked me.	<input type="text"/>
* 20. I could not get going.	<input type="text"/>

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Enter the patient's responses into the CES-D form by choosing one response from the following choices:

- Rarely or None of the Time (Less than 1 Day)
- Some or a Little of the Time (1-2 Days)
- Occasionally or a Moderate Amount of Time (3-4 Days)
- Most or All of the Time (5-7 Days)

To calculate and save the patient information in the CES-D form, all items must be complete.

On the Impairments Tab, the score, date, and score type for the most recent CES-D are displayed in the Scores/Dates (history) field. Select the dropdown to view a listing of the scores, record dates, and score types for all CES-D assessments. You can view (and edit) an individual CES-D assessment by selecting one of the assessment history lines.

Craig Handicap Assessment and Reporting Technique Short Form (CHART-SF)

The Craig Handicap Assessment and Reporting Technique-Short Form (CHART-SF) was designed to provide a simple, objective measure of the degree to which impairments and disabilities result in limitations to participation in meaningful social roles. The CHART-SF has nineteen items that yield the same subscales as the original thirty-two item CHART.

The CHART-SF form has different types of response choices, such as Yes or No, number entry, text entry, and multiple-choice responses. The CHART-SF has six subscale (dimension) sections:

- Physical Independence (physical activities, such as dressing, toileting, mobility)
- Cognitive Independence (remembering, decision-making, judgment)
- Mobility (typical activities)
- Occupation (work, home, recreational activities)
- Social Integration (family and friends; social associations)
- Economic Self-sufficiency (financial resources, including earnings)

CHART-SF Submission Requirements

For the CHART-SF instrument to be calculated and saved, the following fields, along with the required Record Date, Care Type, and Score Type fields, require values.

- Hours Paid Assistance
- Hours Unpaid (Family, Others)

To submit the CHART-SF form, the two fields in the Physical Independence section described above must have responses. Within any one of the subscale sections, if any one of the fields within that section is completed, then all fields in that section are required to save the form.

The Craig Handicap Assessment and Reporting Technique Short Form (CHART-SF) assessment form may be accessed from the Participation and SWLS tab.

CHART-SF Scoring

CHART-SF items are grouped by subscales, also known as dimensions. A dimension score (instrument subscale score) can be calculated only when all items in that dimension have responses; other requirements may apply as well. If the response to questions 18 or 19 is either Don't Know or Refused, the Economic Self-Sufficiency score cannot be calculated.

NOTE: When the Unreimbursed medical expenses exceed the combined annual income for the economic self-sufficiency section, the Economic Self-Sufficiency Score will calculate a zero (0) score.

[For scoring information, refer to the CHART-SF Scoring Algorithm.]

CHART-SF Progress Notes

Progress notes may be written in the application depending on the score type and the care type. For more information about Progress notes, see section [Progress Notes](#).

CHART-SF History

On the Participation & SWLS Tab, the total score, date, and score type for the most recent CHART-SF are displayed in the CHART-SF History field. Select the history dropdown to view a listing of the scores, record dates, and score types for all CHART-SF assessments. You can view (and edit) an individual CHART-SF assessment by selecting one of the assessment history lines.

The subscale scores for the CHART-SF are displayed in the CHART-SF Subscales section of the Participation & SWLS tabs.

In the application, the CHART-SF appears as follows:

Craig Handicap Assessment and Reporting Technique Short Form (CHART-SF)			
Name:	SPINALCORD,EIGHTEEN	* Record Date:	12/29/2006
Division:	442	* Care Type:	<input type="text" value=""/>
* Care Type:	<input type="text" value=""/>	Care Start Date:	<input type="text" value=""/>
Score:	<input type="text" value=""/>	* Score Type:	<input type="text" value=""/>

People with disabilities often need assistance. We would like to differentiate between personal care for physical disabilities and supervision for cognitive problems. First, focus on physical "hands on" assistance. This includes help with eating, grooming, bathing, dressing, management of a ventilator or other equipment, transfers, etc. Keeping in mind these daily activities...

PHYSICAL INDEPENDENCE

1. How many hours in a typical 24-hour day do you have someone with you to provide physical assistance for personal care activities such as eating, bathing, dressing, toileting, and mobility?

* Hours Paid Assistance: Hours

* Hours Unpaid (Family, Others): Hours

SCORE

COGNITIVE INDEPENDENCE

2. How much time is someone with you in your home to assist you with activities that require remembering, decision making, or judgment?

3. How much of the time is someone with you to help you with remembering, decision making, or judgment when you go away from your home?

SCORE

MOBILITY

Now, I have a series of questions about your typical activities.

Are you up and about regularly?

4. On a typical day, how many hours are you out of bed? Hours

5. In a typical week, how many days do you get out of your house and go somewhere? Days

6. In the last year, how many nights have you spent away from your home (excluding hospitalizations)? Days

SCORE

OCCUPATION

How Do You Spend Your Time?

7. How many hours per week do you spend working in a job for which you get paid? Hours

8. How many hours per week do you spend in school working toward a degree or in an accredited technical training program (including hours in class and studying)? Hours

What is your occupation?

9. How many hours per week do you spend in active homemaking including parenting, housekeeping, and food preparation? Hours

10. How many hours per week do you spend in home maintenance activities such as gardening, house repairs, or home improvement? Hours

11. How many hours per week do you spend in recreational activities such as sports, exercise, playing cards, or going to movies? Hours

Please do not include time spent watching TV or listening to the radio.

SCORE

SOCIAL INTEGRATION

With Whom Do You Spend Your Time?

12. How many people do you live with? People

13. Is one of them your spouse or significant other?

Yes

No

Not applicable (subject lives alone)

14. Of the people you live with, how many (others) are relatives? Relatives

15. How many business or organizational associates do you visit, phone, or write to at least once a month? Associates

16. How many friends (non-relatives contacted outside business or organizational settings) do you visit, phone, or write to at least once a month? Friends

17. With how many strangers have you initiated a conversation in the last month (for example, to ask information or place an order)?

SCORE

ECONOMIC SELF-SUFFICIENCY

What Financial Resources Do You Have?

18. Approximately, what was the combined annual income, in the last year, of **all family members in your household**? Consider all sources including wages and earnings, disability benefits, pensions and retirement income, income from court settlements, investments and trust funds, child support and alimony, contributions from relatives, and any other source.)

19. Approximately, how much did you pay last year for medical care expenses? (Consider any amounts paid by yourself or the family members in your household and not reimbursed by insurance or benefits.) *Would you say that your unreimbursed medical expenses are...

SCORE

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Check Your Health (CYH) and Secondary Conditions

The Check Your Health (CYH) form is designed to help identify people who are at risk for secondary conditions. The Secondary Conditions Checklist is designed to highlight the most problematic secondary conditions. These conditions have been grouped into four basic areas: environmental obstacles, medical conditions, adjustment issues, and health and lifestyle issues. The user may select as many secondary conditions as apply.

The Check Your Health (CYH) form appears as follows:

Check Your Health Form

Name:	SPINALCORD,SIXTEEN	* Record Date:	<input type="text"/>	
Division:	442	Care Start Date:	<input type="text"/>	
* Care Type:	<input type="text"/>	* Score Type:	<input type="text"/>	
Score:	<input type="text" value="0"/>	Overall Independence:	<input type="text" value="0"/>	Depression: <input type="text" value="0"/>

To determine your risk for being limited by secondary conditions over the next year or so, rate your overall health and independence over the past 12 months. Also rate how much, if at all, depression has affected your activity and independence over the past year.

1. Overall, would you say your health over the past 12 months was:

2. Overall, would you say that your ability to independently engage in desired activities such as work, recreation, or daily living over the past 12 months was:

3. During the past year, how much would you say that depression limited your activity per week? Depression is more than feeling blue. Symptoms of depression include extreme long-term sadness, loss of pleasure in favorite things and activities, sleep problems, weight loss or gain, thoughts of suicide and/or unexplained crying:

Interpreting Your Total Score

6 - 9 Probably in relatively good health. Probably not experiencing significant problems due to secondary conditions.

4 - 5 Likely to be experiencing some problems due to secondary conditions. The severity of these conditions is not clear. Your health status could improve, or it could worsen.

0 - 3 Highly likely to be experiencing significant problems due to secondary conditions. You may be experiencing a wide range of problems that can be treated or that you can manage yourself with access to information and support. If you have scored in this range, you are strongly encouraged to obtain some assistance.

Secondary Conditions Checklist

Research shows that people with disabilities report experiencing many secondary conditions each year. These conditions may adversely affect your health and independence. Fortunately, many of these conditions can be prevented, managed, or treated. A good place to start is to review the following list of secondary conditions and mark any that you are experiencing.

<p>Environmental Obstacles</p> <p><input type="checkbox"/> Access Problems</p> <p><input type="checkbox"/> Mobility Problems</p> <p><input type="checkbox"/> Equipment Failures</p> <p><input type="checkbox"/> Equipment Injuries to Others</p> <p><input type="checkbox"/> Equipment Injuries</p> <p><input type="checkbox"/> Isolation</p> <p><input type="checkbox"/> Care-related Injuries</p> <p>Adjustment Issues</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Anger</p> <p><input type="checkbox"/> Isolation</p> <p><input type="checkbox"/> Sleep Problems</p>	<p>Medical Conditions</p> <p><input type="checkbox"/> Pressure Sores</p> <p><input type="checkbox"/> Urinary Tract Infection</p> <p><input type="checkbox"/> Spasticity</p> <p><input type="checkbox"/> Contractures</p> <p><input type="checkbox"/> Bowel/Bladder Dysfunction</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Respiratory Problems</p> <p>Health and Lifestyle Issues</p> <p><input type="checkbox"/> Physical Conditioning</p> <p><input type="checkbox"/> Eating/Weight Problems</p> <p><input type="checkbox"/> Alcohol/Drug Abuse</p> <p><input type="checkbox"/> Sleep Problems</p> <p><input type="checkbox"/> Fatigue</p>
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The top section is the Check Your Health (CYH) portion of the form, which has three questions. The lower section is the Secondary Conditions Checklist. These two related instruments have been combined into one form in this application.

For the CYH instrument to be calculated and saved, in addition to the Record Date, Care Type, and Score Type fields, questions 1, 2, and 3 require values.

The Check Your Health (CYH) and Secondary Conditions assessment form can be accessed from the Impairments page. On the Impairments Tab, the score, record date, and score type for the most recent CYH are displayed in the Scores/Dates (history field). Select the history dropdown to view a listing of the score(s), record dates, and score types for all CYH assessments. You can view (and edit) individual assessments by selecting one of the CYH assessment history lines.

Check Your Health Scoring

The following scores are calculated: the Overall Health score, Overall Independence score, Depression score, and the Total Score.

A graph showing the changes in the Check Your Health (CYH) total score over time is displayed on the Impairments Tab.

Secondary Conditions Checklist

The Secondary Conditions Checklist allows the selection of secondary conditions from each of four categories (environmental obstacles, medical conditions, adjustment issues, and health and lifestyle issues). Select as many secondary conditions as apply.

[For scoring information, refer to the CYH Scoring Algorithm.]

Drug Abuse Screening Test (DAST)

The purpose of the Drug Abuse Screening Test (DAST) is to provide a brief, simple, practical, but valid method for identifying individuals who are abusing drugs and to yield a quantitative index score of the degree of problems related to drug use and misuse. The DAST is able to discriminate drug-related problems from alcohol-related problems, indicating that the DAST is sensitive to problems resulting from drug use in particular and not to problems relating more generally to alcohol abuse.

The Drug Abuse Screening Test (DAST) assessment form can be accessed from the Impairments Tab. The DAST form appears as follows:

DAST Form				
Name:	SPINALCORD,SIXTEEN	* Record Date:	<input type="text"/>	
Division:	442	Care Start Date:	<input type="text"/>	
* Care Type:	<input type="text"/>	* Score Type:	<input type="text"/>	
Score:	<input type="text" value="0"/>			
During the past twelve months:				
* 1. Have you used drugs other than those required for medical reasons?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 2. Have you abused prescription drugs?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 3. Do you abuse more than one drug at a time?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 4. Can you get through the week without using drugs (other than those required for medical reasons)?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 5. Are you always able to stop using drugs when you want to?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 6. Do you abuse drugs on a continuous basis?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 7. Do you try to limit your drug use to certain situations?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 8. Have you had "blackouts" or "flashbacks" as a result of drug use?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 9. Do you ever feel bad about your drug abuse?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 10. Does your spouse (or parents) ever complain about your involvement with drugs?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 11. Do your friends or relatives know or suspect you abuse drugs?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 12. Has drug abuse ever created problems between you and your spouse?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 13. Has any family member ever sought help for problems related to your drug use?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 14. Have you ever lost friends because of your use of drugs?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 15. Have you ever neglected your family or missed work because of your use of drugs?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 16. Have you ever been at trouble at work because of drug abuse?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 17. Have you ever lost a job because of drug abuse?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 18. Have you gotten into fights when under the influence of drugs?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 19. Have you ever been arrested because of unusual behavior while under the influence of drugs?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 20. Have you ever been arrested for driving while under the influence of drugs?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 21. Have you ever engaged in illegal activities to obtain drugs?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 22. Have you ever been arrested for possession of illegal drugs?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, or bleeding)?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 25. Have you ever gone to anyone for help for a drug problem?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 26. Have you ever been in a hospital for medical problems related to your drug use?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 27. Have you ever been involved in a treatment program specifically related to drug use?	<input type="radio"/>	Yes	<input type="radio"/>	No
* 28. Have you been treated as an outpatient for problems related to drug abuse?	<input type="radio"/>	Yes	<input type="radio"/>	No
<small>Reproduced or adapted with permission from the Centre of Addiction and Mental Health. Copyright © 1982 Centre of Addiction and Mental Health.</small>				
<input type="button" value="Back"/> <input type="button" value="Print"/> <input type="button" value="Blank Forms"/>		<input type="button" value="Cancel"/> <input type="button" value="Reset"/> <input type="button" value="Calculate"/> <input type="button" value="Submit"/> <input type="button" value="Help"/>		

Patient's responses to the DAST instrument questions may be entered into the form by selecting either *Yes* or *No* for each question. The assessment time frame covers the past 12 months. All questions require responses for the DAST instrument to be calculated and saved.

On the Impairments Tab, the score, record date, and score type for the most recent DAST are displayed in a history field. Select the history dropdown to view a listing of the score(s), record dates, and score types for all DAST assessments. You can view (and edit) individual DAST assessments by selecting one of the assessment history lines.

Duke Severity of Illness (DUSOI) Checklist

The Duke Severity of Illness Checklist (DUSOI) is a generic assessment of the morbidity experienced by a patient. The most serious illness weights the score most heavily, but co-morbidity is included. The DUSOI is computed based on the three most serious conditions, but as many conditions as the clinician desires may be entered. The DUSOI Assessment form appears as follows:

The left side of the form contains the individual diagnosis or health problem section. The Related Diagnoses section on the right side displays the related diagnoses associated with this cluster of diagnoses. The DUSOI Related Diagnoses list displays the associated DUSOI Health Problem, with ICD, Health Problem or diagnosis, score, and record date, which will be shown in order with the highest Score first.

1. Refer to the section “[Sample of Completed DUSOI Assessment](#)” for an example.

Clinicians use the term “clustering” for the grouping of DUSOI health or diagnosis forms.

The following is a summary of steps used to create a DUSOI assessment cluster:

1. Select the ICD for the Diagnosis or Health Problem field. Refer to the “Diagnosis or Health Problem Field” section for details.
2. Select responses for the Symptoms, Complications, and Prognosis fields.
3. In the Treatability/Need for Treatment field, either select the *Questionable*, *No*, or *Yes* button
4. If the Treatability/Need for Treatment field is *Yes*, select a value for the Expected Response to Treatment field.
5. Select the *Calculate* button to view the score for the individual diagnosis or health problem.

NOTE: The calculated Overall DUSOI score for associated DUSOI forms displays in the Score field in the header of the DUSOI form.

6. If all diagnoses have been added, select the *Submit* button to save the DUSOI assessment.

- If there are more diagnoses to be added to this cluster, select the *Add more Diagnoses* button. A summary of the individual health diagnosis or problem is displayed in the Related Diagnoses section. The left side of the form is blank for entry of a new ICD. Repeat this process from step 1.

Button Functions within DUSOI

The following is a general overview of special functionality on the DUSOI assessment.

The *Add More Diagnoses* function is used to create a new associated DUSOI form. This function saves the individual DUSOI assessment temporarily and displays a listing of this diagnosis with its individual score on the right side of the page. The values in the individual DUSOI assessment fields on the left side are removed, and a new diagnosis can be added.

NOTE: The assessments are not saved until the *Submit* button is selected. If individual diagnoses have been added to a cluster, even though a listing of each diagnosis appears on the right, if they have not been submitted, these diagnoses will be deleted if the *Cancel* button is used.

The *Submit* function is used to end the process of creating associated DUSOI forms. This function causes the overall DUSOI score to be calculated and the forms to be submitted.

Diagnosis or Health Problem Field

Diagnoses codes can be selected from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes, including V codes. Select the *ICD Search* button, and the SCI ICD Search window is displayed.

ICD Code	Short Name	Long Name
Select ICD Code: <input type="text" value="diabetes"/>		
<input type="button" value="Submit"/> <input type="button" value="Close"/>		

Enter part of the diagnosis or ICD code in the Search text field. Select the *Submit* button, and the system returns a list of matching ICD codes, along with the short name and long name for the diagnosis or health problem. The ICD Code search utilizes a Remote Procedure Call (RPC) to Vista for ICD lookups.

Spinal Cord Injury & Disorders Outcomes SCI ICD Search		
ICD Code	Short Name	Long Name
250.00	DMII WO CMP NT ST UNCNTR	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED
250.01	DMI WO CMP NT ST UNCNTRL	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE I (JUVENILE TYPE), NOT STATED AS UNCONTROLLED
250.02	DMII WO CMP UNCNRD	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE II OR UNSPECIFIED TYPE, UNCONTROLLED
250.03	DMI WO CMP UNCNRD	DIABETES MELLITUS WITHOUT MENTION OF COMPLICATION, TYPE I (JUVENILE TYPE), UNCONTROLLED

From the list of matching diagnoses, select the desired diagnosis. The selected code and short diagnosis name are displayed in the Diagnosis or Health Problem field on the DUSOI form.

You can add as many DUSOI individual diagnoses as are needed to capture all the patient’s diagnoses or health problems.

DUSOI Scoring

Calculate the value of responses to obtain both the Diagnosis or Health Problem Score and the Overall DUSOI Score for all diagnoses or problems. A Diagnosis or Health Problem Score is computed and displayed on each individual DUSOI form. The DUSOI Overall Score for all associated diagnoses or problems is computed using the three highest Diagnosis or Health Problem scores of associated DUSOI forms.

[For scoring information, refer to the DUSOI Scoring Algorithm.]

Associated DUSOI Forms

DUSOI Forms that are entered from an open DUSOI form using the *Add More Diagnoses* function will be associated with each other. When editing an archived DUSOI assessment, using the *Add More Diagnoses* function will cause new DUSOI forms to be associated with the current group of DUSOI forms. When editing a DUSOI assessment, the user will not be able to modify the record date.

History of Completed DUSOI Forms

On the Impairments Tab, the most recent DUSOI Overall score, record date, and score type is displayed in a history field next to the *DUSOI* button. Select the history dropdown to view a listing of the overall scores, record dates, and score types for all DUSOI assessments. You can view (and edit) DUSOI assessments by selecting one of the assessment history lines.

Sample of Completed DUSOI Assessment

The following example of a completed DUSOI shown below demonstrates the Related Diagnoses section on the right side, with the information for the diagnosis of 826.0 displayed and editable on the left side. The diagnosis of 826.0 has an individual score of 50.

Duke Severity of Illness (DUSOI) Checklist

Name: SPINALCORD,SIXTEEN * Record Date: 04/01/2005
 Division: 442
 * Care Type: Inpatient Rehabilitation Care Start Date: 03/01/2005
 Score: 69.8 * Score Type: Finish

Health Problem or Diagnosis

Enter information about co-existing health problems or diagnoses using a separate DUSOI checklist for each. You can enter as many diagnoses or problems as you deem necessary.

* Diagnosis or Health Problem Score: 50 ICD Search

* Diagnosis or Health Problem: 826.0 FX PHALANX, FOOT-CLOSED

* 1. Symptoms (past week): Moderate

* 2. Complications (past week): Mild

* 3. Prognosis (next six months without treatment): Disability Mild

* 4. Treatability: Need for Treatment
 Questionable
 No
 Yes

[If Yes] Expected Response to Treatment: Good

Add More Diagnoses

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Back Print Blank Forms Cancel Reset Calculate Submit Help

Duke Severity of Illness Analog (DUSOI-A) Scale

The Duke Severity of Illness Analog Scale (DUSOI-A) is a single-item generic assessment of the overall morbidity experienced by a patient based on the clinician’s judgment. The patient’s overall severity of illness during the past week is rated by the clinician by assigning a score from zero through one hundred or by moving a slider along an analog scale. The lowest severity applies to someone whose total set of diagnoses or health conditions results in the fewest symptoms and complications, the least disability and threat to life, the least need for treatment, and the best expected response to treatment if needed. Conversely, the highest severity applies to someone whose total set of diagnoses results in the most symptoms and complications, the most disability and greatest threat to life, the most need for treatment, and the worst expected response to treatment if needed.

The DUSOI-A Assessment form appears as follows:

Duke Severity of Illness (DUSOI) Analog

Name: SPINALCORD,SIXTEEN * Record Date:

Division: 442 Care Start Date:

* Care Type: * Score Type:

Score:

Please mark the appropriate place along the line below to indicate how you would rate this patient's overall severity of illness during the past week.

Lowest severity applies to someone whose total set of diagnoses results in the fewest symptoms and complications, the least disability and threat to life, the least need for treatment, and the best expected response to treatment if needed.

Highest severity applies to someone whose total set of diagnoses results in the most symptoms and complications, the most disability and greatest threat to life, the most need for treatment, and the worst expected response to treatment if needed.

Lowest Severity **Highest Severity**

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

If unable to use the slider control, please enter a number between 0 and 100:

How confident are you that your rating of this patient's severity of illness is accurate? Please choose the appropriate category:

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Back Print Blank Forms Cancel Reset Calculate Submit Help

For the DUSOI-A instrument to be calculated and saved, the following fields, along with the Record Date, Care Type, and Score Type fields, require values:

Instrument Slider or the field “If unable to use the slider control”

“How confident are you that your rating of this patient’s severity of illness is accurate”

The Duke Severity of Illness Analog (DUSOI-A) Scale assessment form can be accessed from the Impairments tab. On the Impairments Tab, the score, record date, and score type for the most recent DUSOI-A are displayed in a history field next to the *DUSOI-A* button. Select the history dropdown to view a listing of the scores, record dates, and score types for all assessments. You can view (and edit) individual assessments by selecting one of the DUSOI-A assessment history lines.

[For scoring information, refer to the *DUSOI-A Scoring Algorithm*.]

Functional Assessment Measure (FAM)

The Functional Assessment Measure (FAM) was developed as an activity measure and as an adjunct to the Functional Independence Measure (FIM) to specifically address the major functional areas that are relatively less emphasized in the FIM, including cognitive, behavioral, communication and community functioning measures. The FAM consists of 12 items, which were developed by clinicians representing each of the disciplines in an inpatient rehabilitation program. The Functional Assessment Measure (FAM) assessment form can be accessed from the Activities tab.

The Functional Assessment Measure (FAM) Assessment form appears as follows:

Functional Assessment Measure (FAM) Form

Name:	SPINALCORD,SIXTEEN	* Record Date:	05/16/2007 <input type="text"/>
Division:	442	Care Start Date:	03/01/2005 <input type="text"/>
* Care Type:	<input type="text" value="Inpatient Rehabilitation"/>	* Score Type:	<input type="text"/>

The purpose of the twelve Functional Assessment Measure (FAM) items is to provide activity measures reflecting communication, psychosocial adjustment, and cognitive functions of the patient. Ratings use the familiar seven-point rating scale to assess the individual's level or degree of independence, amount of assistance required, use of adaptive or assistive devices, and the percentage of a given task completed successfully. Ratings are to reflect actual performance, not capability. A blank rating on any item indicates "not applicable," "untested," or "unknown." The seven-point rating scale is as follows:

1. Swallowing	<input type="text"/>
2. Car Transfers	<input type="text"/>
3. Community Access	<input type="text"/>
4. Reading	<input type="text"/>
5. Writing	<input type="text"/>
6. Speech Intelligibility	<input type="text"/>
7. Emotional Status	<input type="text"/>
8. Adjustment to Limitations	<input type="text"/>
9. Employability	<input type="text"/>
10. Orientation	<input type="text"/>
11. Attention	<input type="text"/>
12. Safety Judgment	<input type="text"/>

● At least one item needs to be completed

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Values may be selected for any of the twelve items from the corresponding dropdown. An item may be left blank, which indicates it is either “not applicable”, “untested”, or “unknown”. For the FAM instrument to be calculated and saved, at least one item requires a response.

This assessment does not have a total score, only a score or rating for each individual activity measure. The most recently completed FAM assessment score(s) and record date are included and displayed on the Activities page. The displayed scores are the ratings for each available individual activity measure, (e.g., Swallowing 7, Car Transfers 5).

On the Activities Tab, the score(s), record date, and score type for the most recent FAM are displayed in a history field next to the *FAM* button. Select the history dropdown to view a listing of the scores, record dates, and score types for all FAM assessments. You can view (and edit) a FAM assessment by selecting one of the assessment history lines.

[For scoring information, refer to the FAM Scoring Algorithm.]

Functional Independence Measure (FIM)

The Functional Independence Measure (Guide for the Uniform Data Set for Medical Rehabilitation, 1996) is the most widely used activity or functional assessment measure in the rehabilitation community. The FIM is an 18-item ordinal scale, used with all diagnoses within a rehabilitation population. The FIM should be completed by appropriately trained professional staff.

The Functional Independence Measure (FIM) Assessment form appears as follows:

Functional Independence Measure (FIM) Form

Name: SPINALCORD,SIXTEEN	* Record Date: 08/24/2005
Division: 442	Care Start Date: <input type="text"/>
* Care Type: <input type="text"/>	* Score Type: <input type="text"/>
Score: 0	Motor Subtotal: 0
	Cognitive Subtotal: 0

SSN: 000-00-0016 Birthdate: 03/04/1933 (72) Gender: M Marital Status: WIDOWWIDOWER Ethnicity: 1 Military Status: <input type="text"/> Rehabilitation Care Start Date: 04/01/2005 Admission Class: <input type="text"/> Finish Date: <input type="text"/> Check if Program Is Interrupted: <input type="checkbox"/> Transfer Date: <input type="text"/> Return Date: <input type="text"/> Transfer Date: <input type="text"/> Return Date: <input type="text"/> Transfer Date: <input type="text"/> Return Date: <input type="text"/> Impairment Category SCD - Traumatic Spinal Cord Dysfunction Impairment Group <input type="text"/> Date of Onset: 02/01/2004 ASIA Impairment Scale: D	<h3>FIM Polar Chart</h3> <p>Write Progress Note</p>	Self Care Eating: <input type="checkbox"/> Grooming: <input type="checkbox"/> Bathing: <input type="checkbox"/> Dressing - Upper Body: <input type="checkbox"/> Dressing - Lower Body: <input type="checkbox"/> Toileting: <input type="checkbox"/> Sphincter Control Bladder Management: <input type="checkbox"/> Bowel Management: <input type="checkbox"/> Transfers Bed, Chair, Wheelchair: <input type="checkbox"/> Toilet: <input type="checkbox"/> Tub, Shower: <input type="checkbox"/> Locomotion Walk/Wheelchair: <input type="checkbox"/> Walk: <input type="radio"/> Wheelchair: <input type="radio"/> Both: <input type="radio"/> Stairs: <input type="checkbox"/> Communication Comprehension: <input type="checkbox"/> Auditory: <input type="radio"/> Visual: <input type="radio"/> Both: <input type="radio"/> Expression: <input type="checkbox"/> Vocal: <input type="radio"/> Nonvocal: <input type="radio"/> Both: <input type="radio"/> Social Cognition Social Interaction: <input type="checkbox"/> Problem Solving: <input type="checkbox"/> Memory: <input type="checkbox"/>
--	---	--

Scoring Key

7 Complete Independence (timely, safely)
 6 Modified Independence (extra time, devices)
 5 Supervision of Setup (cuing, coaxing, prompting)
 4 Minimal Contact Assistance (performs 75% or more of task)
 3 Moderate Assistance (performs 50%-74% of task)
 2 Maximal Assistance (performs 25%-49% of task)
 1 Total Assistance (performs less than 25% of task)

It is required that all fields in the right side column and three fields (Military Status, Admission Class, and Impairment Group) in the left column of the FIM Online form be completed prior to submitting the form.

The user is not required to complete the *Check if program is interrupted* box, the Transfer Date fields, or the Return Date fields. These fields are used only for FIMs with a score type of Finish.

The fields on the right side of the form require a rating from 1 to 7 based on the following scale:

Complete Independence	7
Modified Independence	6
Supervision or Setup	5
Minimal Contact Assistance	4
Moderate Assistance	3
Maximal Assistance	2
Total Assistance	1

A FIM Polar graph is created and saved when the form is calculated or submitted.

For Inpatient Rehabilitation Care Types with a score type of Start, Function Related Group (FRG) classes are calculated in the background and saved to the SCIDO regional database for research purposes. The instrument form does not display any FRG scores when the FRG scores are calculated.

The FIM assessment form can be accessed from the Activities tab. On the Activities Tab, the scores, record dates, and score types for the most recent FIM assessment are displayed in history fields. Select the FIM Total, FIM, Motor, or FIM Cognitive history dropdown to view a listing of the score(s), record dates, and score types for all assessments. You can view (and edit) individual assessments by selecting one of the assessment history lines on the FIM Total Score history list.

[For scoring information, refer to the FIM Scoring Algorithm.]

Kurtzke Expanded Disability Status Scale (EDSS)

The Kurtzke Expanded Disability Status Scale (EDSS) is one instrument that has been commonly used in outcome assessment of individuals with multiple sclerosis. The EDSS is an ordinal scale with some rater variability that has an emphasis on mobility status. It may be relatively insensitive to change at certain levels of disability or activity restrictions.

The EDSS is a single-item generic assessment of the overall activity restrictions experienced by a patient based on the clinician’s judgment. The patient’s functioning is rated from zero for a normal neurological examination to ten for death due to multiple sclerosis. Levels five through ten reflect some degree of ambulation restriction or disability. It is recommended that the Kurtzke Functional Systems Scale (FSS) be completed before the EDSS since it is associated with neurological testing of eight functional systems, pyramidal, cerebellar, brain stem, sensory, bowel and bladder, visual or optic, mental or cerebral, and other functions. These FSS ratings are then used in conjunction with observations and information concerning gait and use of assistive devices to rate the EDSS. The EDSS form appears as follows:

Kurtzke Expanded Disability Status Scale (EDSS) Form

Name:	SPINALCORD,SIXTEEN	* Record Date:	05/16/2007
Division:	442	Care Start Date:	03/01/2005
* Care Type:	Inpatient Rehabilitation	* Score Type:	

* Enter EDSS Scale Value 0.0 - 10.0: 0.0

The Expanded Disability Status Scale (EDSS) ranges from 0 to 10 and is associated with neurological testing of eight Functional Systems: Pyramidal, Cerebellar, Brain Stem, Sensory, Bowel and Bladder, Visual or Optic, Mental or Cerebral, and Other Functions. The abbreviation FS is used to denote the singular and plural forms: Functional System or Functional Systems.

The full description of the EDSS is not included below. Press this button to print the full EDSS description: [Expanded EDSS Descriptions](#)

0.0	Normal neurologic examination (all FS grade 0).
1.0	No disability, minimal signs in one FS (one FS grade 1).
1.5	No disability, minimal signs in more than one FS (more than one FS grade 1).
2.0	Minimal disability in one FS (one FS grade 2, others 0 or 1).
2.5	Minimal disability in two FS (two FS grade 2, others 0 or 1).
3.0	Moderate disability in one FS (one FS grade 3, others 0 or 1) or mild disability in three or four FS (three to four FS grade 2, others 0 or 1).
3.5	Fully ambulatory but with moderate disability in one FS (one FS grade 3) and one or two FS grade 2; or two FS grade 3, or five FS grade 2 (others 0 or 1).
4.0	Fully ambulatory without aid, up and about some 12 hours a day despite relatively severe disability (one FS grade 4 [others 0 or 1] or combinations of lesser grades). Able to walk without aid or rest 500 meters.
4.5	Fully ambulatory without aid, up and about much of the day, able to work a full day, may otherwise have some limitation of full activity or require minimal assistance (one FS grade 4, others 0 or 1 or combinations of lesser grades). Able to walk without aid or rest 300 meters.
5.0	Ambulatory without aid or rest for about 200 meters; disability severe enough to impair full daily activities (one FS grade 5 alone, others 0 or 1; or combinations of lesser grades).
5.5	Ambulatory without aid or rest for about 100 meters; disability severe enough to preclude full daily activities (one FS grade 5 alone, others 0 or 1; or combinations of lesser grades).
6.0	Intermittent or unilateral constant assistance (cane, crutch, or brace) required to walk about 100 meters with or without resting (more than two FS grade 3 or higher).
6.5	Constant bilateral assistance (canes, crutches, or braces) required to walk about 20 meters without resting (more than two FS grade 3 or higher).
7.0	Unable to walk beyond about 5 meters even with aid, essentially restricted to wheelchair; wheels self in standard wheelchair and transfers alone; up and about in wheelchair 12 hours a day (more than one FS grade 4 or higher).
7.5	Unable to take more than a few steps; restricted to wheelchair; may need aid in transfer; wheels self but cannot carry on in standard wheelchair a full day; may require motorized wheelchair (more than one FS grade 4 or higher).
8.0	Essentially restricted to bed or chair, but may be out of bed most of the day; retains many self-care functions; generally has effective use of arms (generally 4 or higher in several FS).
8.5	Essentially restricted to bed much of the day; has some effective use of arm(s); retains some self-care functions (generally 4 or higher in several FS).
9.0	Helpless bed patient; can communicate and eat (mostly 4 or higher in FS).
9.5	Totally helpless bed patient; unable to communicate, eat, or swallow (almost all FS 4 or higher).
10.0	Death due to MS.

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For the Kurtzke EDSS instrument to be calculated and saved, a response must be selected for the “Enter EDSS Scale value” field. The Kurtzke Expanded Disability Status Scale (EDSS) assessment form may be accessed from the Activities tab if the patient has an etiology of multiple sclerosis. On the Activities Tab, the most recent EDSS score, record date, and score type is displayed in a history field. Select the history dropdown to view a listing of the score, record dates, and score types for all assessments. You can view (and edit) individual assessments by selecting one of the assessment history lines.

[For scoring information, refer to the Kurtzke EDSS Scoring Algorithm.]

Kurtzke Functional Systems Scale (FSS)

The Kurtzke Functional Systems Scale (FSS) constitutes one of the most widely used assessment instruments in Multiple Sclerosis. Based on a standard neurological examination, the seven functional systems plus "other" are rated. Each of the FSS is an ordinal clinical rating scale ranging from zero to five or six. It is recommended that the Kurtzke Functional Systems Scale (FSS) be completed before the EDSS since it is associated with neurological testing of eight functional systems, pyramidal, cerebellar, brain stem, sensory, bowel and bladder, visual or optic, mental or cerebral, and other functions.

The FSS Assessment form appears as follows:

The two check boxes and text-entry box for “Specify Function” are not required for the Kurtzke FSS instrument to be calculated and saved. The following fields require values:

- Pyramidal Functions
- Cerebellar Functions
- Brain Stem Functions
- Sensory Functions
- Bowel and Bladder Functions
- Visual or Optic Functions
- Mental or Cerebral Functions
- Other Functions

The Kurtzke Functional Systems Scale (FSS) assessment form can be accessed from the Activities tab if the patient has an etiology of multiple sclerosis.

On the Activities Tab, the most recent FSS score(s), record date, and score type are displayed in a history field. Select the history dropdown to view a listing of all assessments. You can view (and edit) an individual assessment by selecting one of the assessment history lines.

[For scoring information, refer to the Kurtzke FSS Scoring Algorithm.]

Medical Needs Function Modifiers (MNFM)

The Medical Needs and Function Modifiers (MNFM) form contains four items from the Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI) form pertaining to swallowing status, clinical signs of dehydration, bladder frequency ratings of accidents in the past seven days, and bowel frequency ratings of accidents in the past seven days. The IRF-PAI is a common instrument used to assess patients in inpatient rehabilitation facilities to establish case complexities and progress during rehabilitation.

The MNFM form appears as follows:

Medical Needs and Function Modifiers (MNFM) Form

Name: SPINALCORD,SIXTEEN * Record Date: 05/16/2007

Division: 442

* Care Type: Inpatient Rehabilitation Care Start Date: 03/01/2005

* Score Type:

Medical Needs

Swallowing Status:

Clinical Signs of Dehydration:

Function Modifiers

Bladder Frequency of Accidents (in the past seven days):

Bowel Frequency of Accidents (in the past seven days):

• One dropdown selection is required

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Back Print Blank Forms Cancel Reset Submit Help

For the MNFM instrument to be calculated and saved, at least one field must be completed, along with the Record Date, Care Type, and Score Type fields.

The Medical Needs Function Modifier (MNFM) assessment form can be accessed from the Activities tab. The most recent Bowel Accident Frequency rating and Bladder Accident Frequency rating is displayed on the Activities Tab. There is no total score for the MNFM form. To view a listing of all MNFM assessments, select the history field of either the Bowel Accident Frequency or the Bladder Accident Frequency fields on the Activities tab. You can view (and edit) an individual MNFM assessment by selecting one of the assessment history lines.

If responses were selected for the Swallowing Status and Dehydration fields on the MNFM, these values are displayed on the Impairments tab.

[For scoring information, refer to the MNFM Scoring Algorithm.]

PRIME-MD® Depression Screening

The Primary Care Evaluation of Mental Disorders (PRIME-MD) Depression Screening consists of two items to be used as a case-finding depression instrument. The two-question case-finding instrument is a useful measure for detecting depression in primary care. It has similar test characteristics to other case-finding instruments and is less time-consuming. One "Yes" reply is considered a positive screening for depression; further screening for depression is suggested. If there are two "Yes" replies, complete the Center for Epidemiologic Studies Depression Scale (CES-D) form.

The PRIME-MD form appears as follows:

PRIME-MD ® Depression Screening Form			
Name:	SPINALCORD,SIXTEEN	* Record Date:	<input type="text"/>
Division:	442	Care Start Date:	<input type="text"/>
* Care Type:	<input type="text"/>	* Score Type:	<input type="text"/>
Score:	<input type="text"/>		
* 1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?			<input type="radio"/> Yes <input type="radio"/> No
* 2. During the past month, have you often been bothered by little interest or pleasure in doing things?			<input type="radio"/> Yes <input type="radio"/> No
<small>Reproduced with permission to use the two-question depression screening instrument from Mary A. Whooley, M.D. PRIME-MD ® is a registered trademark of Pfizer Inc. Copyright © 1999 Pfizer Inc.</small>			
<input type="button" value="Back"/> <input type="button" value="Print"/> <input type="button" value="Blank Forms"/> <input type="button" value="Cancel"/> <input type="button" value="Reset"/> <input type="button" value="Calculate"/> <input type="button" value="Submit"/> <input type="button" value="Help"/>			

For the PRIME-MD instrument to be calculated and saved, both questions must be completed along with the Record Date, Care Type, and Score Type fields.

The PRIME-MD Depression Screening assessment form can be accessed from the Impairments tab. On the Impairments tab, the most recent PRIME-MD score(s), record date, and score type are displayed in a history field. Select the history dropdown to view a listing of all assessments. You can view (and edit) an individual PRIME-MD assessment by selecting one of the assessment history lines.

[For scoring information, refer to the PRIME-MD Scoring Algorithm.]

Pressure Ulcer Scale for Healing (PUSH)

The Pressure Ulcer Scale for Healing (PUSH) was developed by the National Pressure Ulcer Advisory Panel (NPUAP) as a quick, reliable tool to monitor the change in pressure ulcer status over time. To use the PUSH Tool, the pressure ulcer is assessed and scored on four elements: length of the open wound, width of the open wound, exudate amount, and tissue type. Record the highest current pressure ulcer stage and number of current pressure ulcers on the form. Estimate the amount of exudate after removal of the dressing and before applying any topical agents. Identify the type of tissue. If there is any necrotic tissue, it is scored as 4. If there is any slough, it is scored as 3, even if most of the wound is covered with granulation tissue.

It can be a clinically practical, evidence-based tool for tracking changes in pressure ulcer status when applied at weekly intervals.

The PUSH form appears as follows:

For the PUSH instrument to be calculated and saved, all fields must be completed, along with the Record Date, Care Type, and Score Type fields. The length and width field entries are limited to two post decimal places (i.e. 2.53).

The Pressure Ulcer Scale for Healing (PUSH) assessment form can be accessed from the Medical Complications tab.

On the Medical Complications Tab, the most recent PUSH score, record date, and score type are displayed in a history field. Select the history dropdown to view a listing of the scores, record dates, and score types for all PUSH assessments. You can view (and edit) an individual assessment by selecting one of the PUSH assessment history lines.

[For scoring information, refer to the PUSH Scoring Algorithm.]

Satisfaction with Life Scale (SWLS) (Diener's)

The Satisfaction with Life Scale (SWLS) is a global measure of life satisfaction developed by Diener, Emmons, Larsen & Griffin, 1985. Life satisfaction is distinguished from affective appraisal in that it is more cognitively than emotionally driven. The SWLS consists of 5-items that are completed by the individual whose life satisfaction is being measured.

The SWLS form appears as follows:

Satisfaction With Life Scale (SWLS) Form

Name: SPINALCORD,SIXTEEN	* Record Date: <input type="text"/>
Division: 442	Care Start Date: <input type="text"/>
* Care Type: <input type="text"/>	* Score Type: <input type="text"/>
Score: <input type="text" value="0"/>	

Below are five statements with which you may agree or disagree. Using the scale below, indicate your agreement with each item by choosing the appropriate number in the dropdown list associated with each item. Please be open and honest in responding.

1 = Strongly Disagree

2 = Disagree

3 = Slightly Disagree

4 = Neither Agree Nor Disagree

5 = Slightly Agree

6 = Agree

7 = Strongly Agree

* 1. In most ways my life is close to my ideal.	<input type="text"/>	
* 2. The conditions of my life are excellent.	<input type="text"/>	
* 3. I am satisfied with my life.	<input type="text"/>	
* 4. So far, I have gotten the important things I want in life.	<input type="text"/>	
* 5. If I could live my life over, I would change almost nothing.	<input type="text"/>	

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For the SWLS instrument to be calculated and saved, all fields require a response.

On the Participation & SWLS Tab, the total score, date, and score type for the most recent SWLS are displayed in the SWLS History field. Select the history dropdown to view a listing of the scores, record dates, and score types for all SWLS assessments. You can view (and edit) an individual SWLS assessment by selecting one of the assessment history lines.

[For scoring information, refer to the SWLS Scoring Algorithm.]

SF-8 Health Survey

The SF-8 Health Survey (SF-8) is a generic multipurpose short form (SF) survey of health status. It contains eight questionnaire items plus one item (2b) that has been revised for people who cannot walk or climb stairs. The survey seeks the patient's observations regarding their health during the past four weeks.

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*Item 2b is not part of the SF-8™ Health Survey.

The SF-8 Health Survey form appears as follows:

SF-8™ Health Survey Form

Name:	SPINALCORD,SIXTEEN	* Record Date:	<input type="text"/>
Division:	442	Care Start Date:	<input type="text"/>
* Care Type:	<input type="text"/>	* Score Type:	<input type="text"/>
Physical Component Summary (PCS8):	<input type="text" value="0.0"/>	Mental Component Summary (MCS8):	<input type="text" value="0.0"/>

This survey asks for your views about your health during the past four weeks. This information will help keep track of how you feel and how well you are able to do your usual activities. For each of the following questions, please mark in the box that best describes your answer.

* 1. Overall, how would you rate your health during the past four weeks?

Excellent	Very Good	Good	Fair	Poor	Very Poor
<input type="radio"/>					

* 2a. During the past four weeks, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?

Not at All	Very Little	Somewhat	Quite a Lot	Could not do physical activities
<input type="radio"/>				

* 2b*. If you could not walk or climb stairs during the past four weeks, how much did physical health problems limit your other physical activities?

Not at All	Very Little	Somewhat	Quite a Lot	Could not do physical activities
<input type="radio"/>				

* 3. During the last four weeks, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?

None at All	A Little Bit	Some	Quite a Lot	Could not do daily work
<input type="radio"/>				

* 4. How much bodily pain have you had during the past four weeks?

None	Very Mild	Mild	Moderate	Severe	Very Severe
<input type="radio"/>					

* 5. During the past four weeks, how much energy did you have?

Very Much	Quite a Lot	Some	A Little	None
<input type="radio"/>				

* 6. During the past four weeks, how much did your physical health or emotional problems limit your usual social activities with family or friends?

Not at All	Very Little	Somewhat	Quite a Lot	Could not do social activities
<input type="radio"/>				

* 7. During the past four weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed, or irritable)?

Not at All	Slightly	Moderately	Quite a Lot	Extremely
<input type="radio"/>				

* 8. During the past four weeks, how much did personal or emotional problems keep you from doing your work, school, or other daily activities?

Not at All	Very Little	Somewhat	Quite a Lot	Could not do daily activities
<input type="radio"/>				

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For the SF-8 instrument to be calculated and saved, all fields require responses. After completion of the mandatory SF-8 information, select either Calculate or Submit.

By selecting *Calculate*, the SF-8 instrument displays graphs of the eight scale scores and two component scores. On the SF-8 Scale Scores graph page, after the *Back* button is selected, the SF-8 instrument refreshes and provides the component scores in the header of the instrument.

The SF-8 Health Survey assessment form can be accessed from the Impairments tab. On the Impairments tab, the most recent SF-8 scores, record date, and score type are displayed in a history field. Select the

history dropdown to view a listing of all assessments. You can view (and edit) an individual SF-8 assessment by selecting one of the assessment history lines.

Two composite scores are calculated:

- Physical Component Summary (PCS8)
- Mental Component Summary (MCS8)

Eight subscales are calculated:

- PF - Physical Functioning
- RP - Role Physical
- BP - Bodily Pain
- GH - General Health
- VT - Vitality
- SF - Social Functioning
- RE - Role Emotional
- MH - Mental Health

[For scoring information, refer to the SF-8 Scoring Algorithm.]

Short Form McGill Pain Questionnaire (SF-MPQ)

The Short Form McGill Pain Questionnaire (SF-MPQ) measures a patient’s subjective pain experience by using two dimensions of pain, sensory pain rating index (S-PRI) and affective pain rating index (A-PRI), and a total pain rating index (T-PRI). The objective of the MPQ is to facilitate the communication regarding pain between patients and health care professionals. The patient is also provided the opportunity to rate their present pain intensity index (PPI) and use a visual analogue scale to rate their pain from zero (lowest severity) to one-hundred (highest severity). The SF-MPQ form appears as follows:

Short Form McGill Pain Questionnaire (SF-MPQ) Form

Name:	SPINALCORD,SIXTEEN	* Record Date:	<input type="text"/>
Division:	442	Care Start Date:	<input type="text"/>
* Care Type:	<input type="text"/>	* Score Type:	<input type="text"/>
Score:	<input type="text" value="0"/>		

Sensory Pain Rating Index (S-PRI):	<input type="text" value="0"/>
Affective Pain Rating Index (A-PRI):	<input type="text" value="0"/>
Total Pain Rating Index (T-PRI):	<input type="text" value="0"/>
Visual Analogue Scale:	<input type="text"/>
Pain Scale (PPI):	<input type="text" value="0"/>

Indicate on the line below how bad your pain is. The left end of the line means no pain; the right end means the worst possible pain.

Lowest Severity ▬ **Highest Severity**

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

If unable to use the slider control, please enter a number between 0 and 100:

Enter pain scale from 0 = No pain to 10 = Worst imaginable pain:

* 1. Throbbing:	<input type="text"/>
* 2. Shooting:	<input type="text"/>
* 3. Stabbing:	<input type="text"/>
* 4. Sharp:	<input type="text"/>
* 5. Cramping	<input type="text"/>
* 6. Gnawing:	<input type="text"/>
* 7. Hot - Burning:	<input type="text"/>
* 8. Aching:	<input type="text"/>
* 9. Heavy:	<input type="text"/>
* 10. Tender:	<input type="text"/>
* 11. Splitting:	<input type="text"/>
* 12. Tiring - Exhausting:	<input type="text"/>
* 13. Sickening:	<input type="text"/>
* 14. Fearful:	<input type="text"/>
* 15. Punishing - Cruel:	<input type="text"/>

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For the SF-MPQ instrument to be calculated and saved, all fields require responses.

The Short Form McGill Pain Questionnaire (SF-MPQ) assessment form can be accessed from the Medical Complications tab. On the Medical Complications tab, the most recent SF-MPQ scores, record date, and score type are displayed in a history field. Select the history dropdown to view a listing of all SF-MPQ assessments. You can view (and edit) an individual SF-MPQ assessment by selecting one of the assessment history lines.

Registration Ancillary Data Entry Form

The Ancillary Data Entry Form may be accessed from the Registration page. Ancillary data consists of sources of care, referral sources, bowel care information, and remarks.

Registration Ancillary Data Entry Form

Name: SPINALCORD,SIXTEEN Division: 442

Additional Care VAMC:

Non-VA Care:

Referral Source:

Referral VA:

Initial Rehabilitation Site:

Initial Rehabilitation Discharge Date: 

Bowel Care Reimbursement (BCR): Yes No

BCR Date Certified: *(Enter date of Bowel Care Reimbursement Certification)* 

BCR Provider:

Remarks:

For the Ancillary Date Entry form to be submitted and saved, at least one field must be completed.

Additional Care VAMC

To fill in the Additional Care VAMC field, select the site where additional VAMC care is provided.

Non-VA Care

The Non-VA Care field is text entry. To fill in the field, type in the site where non-VA care is provided.

Referral Source

The Referral Source field shows the type of facility that referred the patient to the VA. Select from the following.

- VA = Other VA
- CH = Community Hospital
- NH = Nursing Home
- PV = PVA
- SF = Self
- DD = Dept of Defense
- NN = Non-VA Care
- UN = Unknown or Other

Referral VA

The Referral VA field can be selected from the dropdown list.

Initial Rehabilitation Site

To indicate the patient's Initial Rehabilitation Site, select from the dropdown one of the following values:

- CH = Community Hospital
- VS = VAMC with SCI Center
- VN = VAMC without SCI Center
- UN = Unknown or Other

Initial Rehabilitation Discharge Date

The Initial Rehabilitation Discharge Date is a date field for recording when the rehabilitation discharge occurred. The date can be manually entered or selected by selecting the Calendar icon to designate the date when the patient was discharged from rehabilitation.

Bowel Care Reimbursement (BCR)

To indicate whether the patient is being reimbursed for their bowel care, select either the *Yes* or *No*.

BCR Certified

The BCR Certified field is a date field for recording if the patient has been certified for bowel care. The date can be manually entered or selected by selecting the Calendar icon to designate the date when the patient received certification for bowel care.

BCR Provider

The BCR Provider field is text entry. Enter the patient's bowel care provider.

Remarks

The Remarks field is text entry. To complete the field, type in any remarks (limited to 65 characters) to enhance care or outcomes.

Patient Education Form

The Patient Education form is used to record the dates the patient was given educational materials or training on sixteen health-related topics. The Patient Education form is accessible from the Registration tab.

Patient Education Form		
Name: SPINALCORD,SIXTEEN	Record Date: 06/23/2006	Division: 442
The veteran has received education on the following topics:	Education Date	
1. Accessing benefits and community resources:	<input checked="" type="radio"/> Yes <input type="radio"/> No	03/24/2004
2. Bladder management:	<input checked="" type="radio"/> Yes <input type="radio"/> No	07/01/2001
3. Bowel management:	<input type="radio"/> Yes <input checked="" type="radio"/> No	08/01/2005
4. Medication:	<input checked="" type="radio"/> Yes <input type="radio"/> No	07/01/2005
5. Follow-up medical care:	<input checked="" type="radio"/> Yes <input type="radio"/> No	07/01/2005
6. Securing and managing personal care attendants:	<input checked="" type="radio"/> Yes <input type="radio"/> No	07/01/2005
7. Medical nutrition therapy:	<input checked="" type="radio"/> Yes <input type="radio"/> No	07/01/2005
8. Psychosocial issues:	<input checked="" type="radio"/> Yes <input type="radio"/> No	07/01/2005
9. Pulmonary care:	<input checked="" type="radio"/> Yes <input type="radio"/> No	07/01/2005
10. Sexual counseling and education:	<input checked="" type="radio"/> Yes <input type="radio"/> No	07/01/2005
11. Reproductive health issues:	<input checked="" type="radio"/> Yes <input type="radio"/> No	07/01/2005
12. Skin care:	<input checked="" type="radio"/> Yes <input type="radio"/> No	09/08/2005
13. Chemical use/abuse/dependency:	<input checked="" type="radio"/> Yes <input type="radio"/> No	07/01/2002
14. Leisure time:	<input checked="" type="radio"/> Yes <input type="radio"/> No	07/01/2005
15. Primary prevention:	<input checked="" type="radio"/> Yes <input type="radio"/> No	02/01/2002
16. Secondary prevention:	<input checked="" type="radio"/> Yes <input type="radio"/> No	02/01/2002

Once a patient has received educational material on one of the sixteen subjects, select the *Yes* button and enter the date that the information was given in the date box. Manually enter the date or select the date from the calendar icon. If the patient was offered the educational material but declined, select the *No* button and enter the date the material was offered.

To submit and save the form, at least one selection with an associated date must be completed.

Appendix D: Reports

The following reports are described in this section:

[Influenza Diagnoses and Treatment Report](#)
[Influenza Immunizations Report](#)
[Pain Assessment and Treatment Report](#)
[Pneumonia and Respiratory Report](#)
[Pneumococcal Immunizations Report](#)
[Pressure Ulcer Report](#)
[Urinary Tract Infections Report](#)
[RAI-MDS Quality Indicators Report](#)
[RAI-MDS Resource Utilization Groups \(RUGS\) Report](#)
[Inpatient Rehabilitation Outcomes Report Topics Descriptions](#)
[Outpatient Rehabilitation Outcomes Report Topics Descriptions](#)
[Continuum of Care - Inpatient Outcomes Report Topics Descriptions](#)
[Annual Evaluation Outcomes Report Topics Descriptions](#)
[Custom Reports](#)

All the reports can be accessed from the Reports tab. Some of the reports can be accessed from another Tab. For example, the first seven reports listed above can be accessed from the Medical Complications tab as well as the Reports Tab.

Influenza Diagnoses and Treatment Report

The Influenza Diagnoses and Treatment Report displays VistA information about influenza-related diagnoses, antiviral medications prescribed, influenza-related microbiology and chemistry laboratory reports, chest radiology results, and discharge locations following inpatient treatment of influenza incidents.

The Influenza Diagnoses and Treatment Report may be accessed from the Medical Complications tab as well as from the Reports tab.

Spinal Cord Injury and Disorders Outcomes

Name: SPINALCORD,FOURTEEN Date of Birth: 10/23/1946 (deceased) Neuro. Level: C02 ASIA: D Next AE Due: 03/02/2005
 SSN: 000-00-0014 Education: SC Employment: UU Bladder Drainage: IC Pressure Ulcer: 2

Influenza Diagnoses and Treatment Report Select date range. The default is five years. All Results Select

Influenza-Related Diagnoses:

Date	ICD	Description
10/07/1997	V04.8	VACCIN FOR INFLUENZA

Influenza Laboratory Results:

Lab Results - [Micro Results]
Text

Lab Results - [Chemistry Results]
Text

Chest Radiology Results (Influenza):

Date	CPT	Description
------	-----	-------------

Antiviral Medications:

Date	Name	Code
OCT 09, 2004	AMANTADINE HCL 100MG CAP	AM800
APR 22, 2004	AMANTADINE HCL 100MG CAP	AM800

Discharge Locations:

Date	Description
AUG 09, 2002@11:45:24	RETURN TO COMMUNITY-INDEPENDENT

Print Back Help

Cover Sheet Registration Impairments **Medical Complications** Activities Participation & SWLS Reports

Influenza Immunizations Report

The Influenza Immunizations Report displays Vista information about influenza vaccination medications ordered for the patient, and influenza vaccination diagnoses and procedure codes recorded. This report cannot be used to document performance measure conformance due to various methods of recording doses.

The Influenza Immunizations Report may be accessed from the Medical Complications tab as well as from the Reports tab.

Spinal Cord Injury and Disorders Outcomes

Name: SPINALCORD,FOURTEEN	Date of Birth: 10/23/1946 (58 yrs.)	Neuro. Level:	ASIA:	Next AE Due: 08/24/2005
SSN: 000-00-0014	Education: CG	Employment: RT	Bladder Drainage: IC	Pressure Ulcer: 2

Influenza Immunizations Report

Review Influenza Vaccination Clinical Reminders in CPRS

Influenza Vaccination Pharmaceuticals:

Date	Name	Code

Select date range. The default is five years.

All Results
▼
Select

Influenza Vaccination Procedures (CPT)

Date	CPT	Description
11/29/2001	90658	FLU VACCINE, 3 YRS, IM
11/29/2001	90471	IMMUNIZATION ADMIN

Print
Back
Help

Influenza Vaccination Diagnoses (ICD):

Date	ICD	Description

Cover Sheet	Registration	Impairments	Medical Complications	Activities	Participation & SWLS	Reports
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Pain Assessment and Treatment Report

The Pain Assessment and Treatment Report displays SF-MPQ and PPI scores, pain alleviation drugs, pain management diagnoses and procedures, and Transcutaneous Electrical Nerve Stimulation (TENS) trial dates.

The Pain Assessment and Treatment Report may be accessed from the Medical Complications tab as well as from the Reports tab.

Select date range. The default is five years.
 Five Years [v] Select

Pain Assessment and Treatment Report

McGill Pain Questionnaire (SF-MPQ) Scores:

Type	Score	Score Type	Record Date

SF-MPQ and PPI

Pain Intensity (PPI) Scores:

Type	Score	Score Type	Record Date
PAIN	5		03/01/2005
PAIN	5		08/10/2004

Pain Alleviation Drugs:

NSAIDs Analgesics:

Date	Name	Code
MAY 13, 2002	ASPIRIN 325MG TAB	CN103
MAY 13, 2002	ASPIRIN 325MG TAB	CN103

AntiConvulsants:

Date	Name	Code

Pain Management Surgical Diagnoses:

Date	ICD	Description

Tricyclic Analgesics:

Date	Name	Code

Opioid Analgesics:

Date	Name	Code

Management Surgical Procedures:

Date	CPT	Description

Local Anesthetics:

Date	Name	Code
AUG 04, 2002	LIDOCAINE 0.5% (5MG/ML) W/EPI MDV	CN204

Other Medications:

Date	Name	Code
APR 26, 2004	AMITRIPTYLINE 25/PERPHENAZINE 4MG TAB	CN900

Transcutaneous Electrical Nerve Stimulation (TENS):

Date	CPT	Description

Print Back Help

Cover Sheet
Registration
Impairments
Medical Complications
Activities
Participation & SWLS
Reports

Pneumonia and Respiratory Report

The Pneumonia and Respiratory Report displays Vista information about increased aspiration risks due to swallowing difficulties or feeding tubes, pneumonia or atelectasis diagnoses, intubation procedures, chest radiology results, sputum laboratory results, and discharge locations following inpatient treatment of pneumonias.

The Pneumonia and Respiratory Report may be accessed from the Medical Complications tab as well as from the Reports tab.

Patient Search
 Name: SPINALCORD,ONE
 SSN : 000-00-0001

Spinal Cord Injury and Disorders Outcomes

Date of Birth : 09/22/1927 (78 yrs.)
 Education:
 Neuro. Level: C02
 Employment: UU
 ASIA: B
 Bladder Drainage:
 Next AE Due: 06/12/2006
 Pressure Ulcer:

Logout

Ventilator Equip./Supplies?: N

Pneumonia and Respiratory Report

Select date range. The default is five years.

Nutrition or Dietary Precautions:

Date	Description

Pneumonia-Related Diagnoses (# of Dx: 0)

Date	ICD	Description

Chest Radiology Results:

Date	CPT	Description
01/03/2005	71010	CHEST X-RAY
12/23/2004	71020	CHEST X-RAY
12/22/2004	71010	CHEST X-RAY
12/17/2004	71020	CHEST X-RAY
12/15/2004	71020	CHEST X-RAY

PEG and Gastrostomy Tube ICD Codes:

Date	ICD	Description

Atelectasis Incidents (# of Dx: 0)

Date	ICD	Description

Sputum Laboratory Results:

Date	Description

Supply Orders for Nasogastric and Feeding Tubes:

Date	Name	Code

Intubation Procedure Codes:

Date	CPT	Description

Discharge Locations:

Date	Description
MAY 18, 2006@14:37:34	-----
MAY 12, 2003@09:09:44	RETURN TO COMMUNITY-INDEPENDENT
FEB 19,	RETURN TO COMMUNITY-

Cover Sheet
Registration
Impairments
Medical Complications
Activities
Participation & SWLS
Reports

Pneumococcal Immunizations Report

The Pneumococcal Immunizations Report displays VistA information about pneumococcal vaccination medications ordered for the patient, and pneumococcal vaccination diagnoses and procedure codes recorded. This report cannot be used to document performance measure conformance due to various methods of recording doses.

The Pneumococcal Immunizations Report may be accessed from the Medical Complications tab as well as from the Reports tab.

Pneumococcal Immunizations Report

Review Pneumococcal Vaccination Clinical Reminders in CPRS Select date range. The default is five years.
All Results

Pneumococcal Vaccination Pharmaceuticals:

Date	Name	Code

Pneumococcal Vaccination Procedures (CPT):

Date	CPT	Description
11/09/1997	90732	PNEUMOCOCCAL VACCINE
10/07/1997	90732	PNEUMOCOCCAL VACCINE

Pneumococcal Vaccination Diagnoses (ICD):

Date	ICD	Description
10/07/1997	V03.82	PROPHY VACC. STREP PNEU

Cover Sheet | Registration | Impairments | **Medical Complications** | Activities | Participation & SWLS | Reports

Pressure Ulcer Report

The Pressure Ulcer Treatment Report displays SCIDO information entered on the Medical Complications Tab and PUSH assessments and also displays VistA information about pharmacy supplies and prosthetic devices, diagnoses, surgeries, complications, radiological studies, and laboratory results related to pressure ulcers.

The Pressure Ulcer Treatment Report may be accessed from the Medical Complications tab as well as from the Reports tab.

The Treatment Completion Information field is populated from Pressure Ulcer Finish data entered on the Medical Complications Tab. The Pressure Ulcer Risk field is populated from Risk data entered on the Medical Complications Tab.

Patient Search
 Name: SPINAL_CORD PTONE Date of Birth : 06/01/1931 (deceased)
 SSN : 000-00-1001 Education: CG

Spinal Cord Injury and Disorders Outcomes

Neuro. Level: ASIA: Next AE Due: 02/02/2005
 Employment: UU Bladder Drainage: Pressure Ulcer:

Logout

Select date range. The default is five years.
 Five Years Select

Treatment Completion Information:

Record Date	Open / Closed	Predominant Position	Elapsed Time to Achieve Healing

Pressure Ulcer and Associated Diagnoses:

Date	ICD	Description

Radiology Results:

Date	CPT	Description	Comment

Pharmacy Supplies:

Date	Name	Code

Surgical Diagnoses:

Date	ICD	Description

Laboratory Results:

Complete Blood Count - JAN 11, 2003@11:35:06

Test Name	Result	Units	Ref. Range	
			Low	High
WBC	6.09	K/cmm	3.79	9.97
HGB	10.3	L g/dL	12	14
HCT	33.2	L %	37	47

Complete Blood Count - JUL 28, 2002@19:49:02

Test Name	Result	Units	Ref. Range	
			Low	High
WBC	7.3	K/cmm	3.9	11.6
HGB	10.6	L g/dL	12	14
HCT	31.5	L %	37	47

Complete Blood Count - JUL 28, 2002@19:49:01

Test Name	Result	Units	Ref. Range	
			Low	High
PROTEIN TOTAL	6.2	g/dL	6.4	8.3

Prosthetic Device Codes:

Date	Description	Code

Surgical Procedures:

Date	CPT	Description

PUSH Scores:

Record Date	Care Type	Score Type	Total Score	Highest Stage Ulcer	Number of Ulcers

Surgical Complications:

Date	ICD	Description

Pressure Ulcer Risk:

Record Date	Risk Level	Risk Instrument Name

Print Back Help

Cover Sheet
Registration
Impairments
Medical Complications
Activities
Participation & SWLS
Reports

Urinary Tract Infections Report

The Urinary Tract Infections Report displays Vista information about urinary tract diagnoses, surgical procedures, radiological studies of the urinary tract, and urinalysis, microbiology, and CBC laboratory results related to urinary tract infections.

The Urinary Tract Infections Report may be accessed from the Medical Complications tab as well as from the Reports tab.

Spinal Cord Injury and Disorders Outcomes Logout

Name: SPINALCORD,ONE Date of Birth: 09/22/1927 (78 yrs.) Neuro. Level: C02 ASIA: B Next AE Due: 06/12/2006
 SSN: 000-00-0001 Education: Employment: UU Bladder Drainage: Pressure Ulcer:

Urinary Tract Infections Report Select date range. The default is five years.
 Five Years Select

Bladder Drainage:

Urinary Tract Diagnoses

Date	ICD	Description
05/12/2003	599.7	HEMATURIA
05/12/2003	599.7	HEMATURIA

Urinalysis

Test Name	Result	Units
SPECIFIC GRAVITY	1.005	

Microbiology, Urine

Microbiology - DEC 14, 2004@07:54:43 [URINE, RANDOM]

Text

<10,000 CFU/ML EACH OF ONE OR MORE ORGANISMS.

Complete Blood Count

Specimen: Blood - MAY 14, 2003@06:99:01

Test Name	Result	Units
WBC	10.0	10 ⁹ /L

Microbiology, Blood

Microbiology - MAR 12, 2003@08:11:43 [BLOOD]

Text

NO GROWTH IN 7 DAYS

Urinary Tract Radiology Results

Date	CPT	Description
05/19/2003	74400	CONTRST X-RAY, URINARY TR
05/19/2003	74400	CONTRST X-RAY, URINARY TR

Print Back Help

Cover Sheet Registration Impairments Medical Complications Activities Participation & SWLS Reports

RAI-MDS Quality Indicators Report

The RAI-MDS Quality Indicators Report provides information for a specific patient on twenty-four quality indicators derived from the RAI-MDS. The default date for this report is the previous month. The user can also select a different month from the dropdown for a report. Information regarding these twenty-four quality indicators is displayed if the patient is in a JCAHO Long-Term Care Setting in the VA. Even though information may not be available for the specific patient, summary information regarding these twenty-four quality indicators at both the regional and national levels will be provided.

Patient Search		Spinal Cord Injury and Disorders Outcomes						Logout							
Name: SPINALCORD,FOURTEEN SSN : 000-00-0014		Date of Birth : 10/23/1946 (deceased) Education: SC		Neuro. Level: C02 Employment: UU		ASIA: D Bladder Drainage: IC		Next AE Due: 03/02/2005 Pressure Ulcer: 2							
RAI-MDS Quality Indicators															
Date Range: 12/01/2005 - 12/31/2005				Creation Time: 03/22/2006				Select date range							
				SCI Center Region: Region				The default is the previous month.							
								Dec 2005 Submit							
Domain/Quality Indicator	Pt Num	Regional SCI			National SCI			Domain/Quality Indicator	Pt Num	Regional SCI			National SCI		
		Num	Den	%	Nat %	%	Rank			Num	Den	%	Nat %	%	Rank
Accidents								Nutrition/Eating							
1. Incidence of new fractures	0	0	0	0.00%	0.00%	100.0%		13. Prevalence of weight loss	0	0	0	0.00%	0.00%	100.0%	
2. Prevalence of falls	0	0	0	0.00%	0.00%	100.0%		14. Prevalence of tube feeding	0	0	0	0.00%	0.00%	100.0%	
Behavior/Emotional Patterns								15. Prevalence of dehydration	0	0	0	0.00%	0.00%	100.0%	
3. Prevalence of behavioral symptoms affecting others								Physical Functioning							
Global	0	0	0	0.00%	0.00%	200.0%		16. Prevalence of bedfast residents	0	0	0	0.00%	0.00%	100.0%	
High Risk	0	0	0	0.00%	0.00%	100.0%		17. Incidence of decline in late loss ADLs	0	0	0	0.00%	0.00%	100.0%	
Low Risk	0	0	0	0.00%	0.00%	100.0%		18. Incidence of decline in ROM	0	0	0	0.00%	0.00%	100.0%	
4. Prevalence of symptoms of depression	0	0	0	0.00%	0.00%	100.0%		Psychotropic Drug Use							
5. Prevalence of symptoms of depression without antidepressant therapy	0	0	0	0.00%	0.00%	100.0%		19. Prevalence of antipsychotic use in the absence of psychotic or related conditions							
Clinical Management								Global	0	0	0	0.00%	0.00%	200.0%	
6. Use of nine or more different medications	0	0	0	0.00%	0.00%	100.0%		High Risk	0	0	0	0.00%	0.00%	100.0%	
Cognitive Patterns								Low Risk	0	0	0	0.00%	0.00%	100.0%	
7. Incidence of cognitive impairment	0	0	0	0.00%	0.00%	100.0%		20. Prevalence of antianxiety/hypnotic use	0	0	0	0.00%	0.00%	100.0%	
Elimination/Incontinence								21. Prevalence of hypnotic use more than two times last week	0	0	0	0.00%	0.00%	100.0%	
8. Prevalence of bladder or bowel incontinence								Quality of Life							
Global	0	0	0	0.00%	0.00%	200.0%		22. Prevalence of daily physical restraints	0	0	0	0.00%	0.00%	100.0%	
High Risk	0	0	0	0.00%	0.00%	100.0%		23. Prevalence of little or no activity	0	0	0	0.00%	0.00%	100.0%	
Low Risk	0	0	0	0.00%	0.00%	100.0%		Skin Care							
9. Prevalence of occasional or frequent bladder or bowel incontinence without a toileting plan	0	0	0	0.00%	0.00%	100.0%		24. Prevalence of stage 1-4 pressure ulcers							
10. Prevalence of indwelling catheter	0	0	0	0.00%	0.00%	100.0%		Global	0	0	0	0.00%	0.00%	200.0%	
11. Prevalence of fecal impaction	0	0	0	0.00%	0.00%	100.0%		High Risk	0	0	0	0.00%	0.00%	100.0%	
Infection Control								Low Risk	0	0	0	0.00%	0.00%	100.0%	
12. Prevalence of urinary tract infections	0	0	0	0.00%	0.00%	100.0%									

Back Cancel Print Help

RAI-MDS Resource Utilization Groups (RUGS) Report"

The RAI-MDS Resource Utilization Groups (RUG) Report provides information about resource utilization groups, assessment activities of daily living, and RUG case mix index weights for all Veterans at the SCI regional level for Veterans with SCI in JCAHO Long-Term Care Settings in the VA.

Patient Search		Spinal Cord Injury and Disorders Outcomes				Logout	
Name: SPINALCORD.FOURTEEN	Date of Birth: 10/23/1946 (deceased)	Neuro. Level: C02	ASIA: D	Next AE Due: 03/02/2005			
SSN: 000-00-0014	Education: SC	Employment: UU	Bladder Drainage: IC	Pressure Ulcer: 2			
RAI-MDS Resource Utilization Groups (RUG)							
Date Range: 11/01/2005 - 11/30/2005		Creation Time: 03/22/2006		Select date range			
Avg CMI Wt: 19.0 Total Assmts: 29		SCI Center Region: Tampa		The default is the previous month.			
				Nov 2005		Submit	
SSN	Facility City	RUG Wt Set	RUG	Assmt ADL	CMI Wt RUG		
	CHEYENNE	URBAN	CB1	12	21		
	CHEYENNE	URBAN	CC1	18	23		
	CHEYENNE	URBAN	CA1	4	17		
	CHEYENNE	URBAN	CA1	4	17		
	CHEYENNE	URBAN	SE2	17	31		
	CHEYENNE	URBAN	PD2	13	16		
	CHEYENNE	URBAN	PD1	13	15		
	CHEYENNE	URBAN	SSC	17	28		
	CHEYENNE	URBAN	SE3	14	36		
	CHEYENNE	URBAN	CA1	4	17		
	CHEYENNE	URBAN	PE1	17	18		
	CHEYENNE	URBAN	CA1	4	17		
	CHEYENNE	URBAN	SE1	18	29		
	CHEYENNE	URBAN	CB1	16	21		
	CHEYENNE	URBAN	PA1	4	1		
	CHEYENNE	URBAN	PA1	4	1		
	CHEYENNE	URBAN	CA1	4	17		
	CHEYENNE	URBAN	CA1	9	17		
	CHEYENNE	URBAN	PD1	12	15		
	CHEYENNE	URBAN	CA1	4	17		
	CHEYENNE	URBAN	CA1	6	17		
	CHEYENNE	URBAN	SSB	15	26		
	CHEYENNE	URBAN	SE2	12	31		
	CHEYENNE	URBAN	SSB	15	26		
	CHEYENNE	URBAN	PD1	11	15		
	CHEYENNE	URBAN	SSA	4	24		
	CHEYENNE	URBAN	CC2	18	27		
	CHEYENNE	URBAN	CA1	4	17		
	CHEYENNE	URBAN	CB1	16	21		
Total # of Assessments: 29				Total CMI Wt		578	
RUG Model/Logic Version: 44/51 RUG Weight Set: Medicare PPS Urban--07/01/98 Reference: MDS 2.0 UserIDs Manual Updated 2/99, RUG-III Classification System, Appendix G, Briggs Corporation.							
						Back Cancel Print Help	

Cumulative Reports

Cumulative Reports produce statistical reports of Outcomes information across diagnostic categories. A definition of each row displayed in the reports is provided in this section for four reports:

Inpatient Rehabilitation Outcomes displays demographics, length of stay, a variety of inpatient rehabilitation effectiveness and efficiency indices, and benchmarks from the MSCIS for some of these indices. This report may be useful in summarizing inpatient rehabilitation outcomes for interested stakeholders, patients, and accreditation organizations. A user-selected date range of care close dates reflects Inpatient Rehabilitation Episodes of Care for inclusion in this report.

Outpatient Rehabilitation Outcomes displays demographics, FIM and SWLS Change, FIM Goal Attainment, and FIM and SWLS durability for Outpatient Rehabilitation Episodes of Care having care close dates within a user-selected date range.

Continuum of Care Inpatient Outcomes Report displays a summary of demographics, length of stay, FIM and SWLS Change, FIM Efficiency, FIM goal attainment, and FIM and SWLS durability for patients within a selected range of assessment close dates for continuum of care inpatient care type.

Annual Evaluation Outcomes Report displays a summary of demographics, FIM, CHART-SF, and Diener's SWLS assessments that have been provided within a selected date range.

The report topics are broken down by the following diagnostic categories:

Diagnostic Categories

Hi-Tetra	Neurological Level is C1-C4 and ASIA Impairment = A, B, or C
Lo-Tetra	Neurological Level is C5-C8 and ASIA Impairment = A, B, or C
Paraplegia	Neurological Level is T1-S5 and ASIA Impairment = A, B, or C
ASIA D	Any Neurological Level and ASIA Impairment = D
ALL	All Neurological Levels and all ASIA Impairment values (except Unknown)

Inpatient Rehabilitation Outcomes Report Topics Descriptions

Inpatient Rehabilitation Outcomes Report Topics	
Report Topic	Description
# and % of Patients	Number of patient datasets in the diagnostic category and Percentage of datasets in all diagnostic categories that number represents. % is the number of diagnostic datasets divided by number of all datasets.
Age (yrs)	Calculate age of individual patient for each dataset in diagnostic category. Calculate Average patient age for each diagnostic category
Age Range	Range of ages in datasets, from the age of the youngest person to the age of the oldest person for each diagnostic category.
Gender (% Male pts)	Percentage of males in diagnostic category.
Length of Rehab (days)	To use a dataset, Care Close Date and Care Start Date must have non-null values. If Return Date and Transfer Date are null, then the length of interruption is 0 days. First calculate the individual patient's length of rehab for each dataset: (Care Close Date - Care Start Date - Interruption in Care Length 1 - Interruption in Care Length 2 - Interruption in Care Length 3) Then using the individual values for dataset's length of rehabilitation, calculate the average length of rehabilitation for each diagnostic category. Interruption in Care Length = Return Date - Transfer Date

Inpatient Rehabilitation Outcomes Report Topics	
Report Topic	Description
Length of Rehab Range	Range of length of rehabilitation from the fewest number of days to the most number of days within datasets used for each diagnostic category.
Total FIM Change	To use a dataset, it must have a FIM assessment of score type Finish and a FIM assessment of score type Start; FIM total score for each assessment must have a non-null value. First calculate each individual's FIM Change for each dataset: Total FIM Change = FIM Total score at Finish - FIM Total score at Start Then calculate the Average value of FIM Change for each diagnostic category.
MSCIS Total FIM Change	Constant values populated by system. Display only: Hi Tetra 12.4 Lo Tetra 27.8 Para 41.5 ASIA D 41.2 ALL 35.9
FIM Efficiency	To use a dataset, it must have a FIM assessment of score type Finish and a FIM assessment of score type Start; FIM total score for each assessment must have a non-null value; the system must be able to calculate the length of rehabilitation. First calculate individual's FIM Efficiency for each dataset within each diagnostic category: FIM Efficiency = Total FIM Change / Length of Rehabilitation Then calculate the Average FIM Efficiency value for each diagnostic category.
MSCIS FIM Efficiency	Constant values populated by system. Display only: Hi Tetra 0.13 Lo Tetra 0.28 Para 0.76 ASIA D 0.84 ALL 0.55
FIM Goal Attainment	To use a dataset, it must have a FIM assessment of score type Finish and a FIM assessment of score type Goal; FIM total score for each assessment must have a non-null value. First calculate the individual values for FIM Goal attainment for each dataset in the diagnostic category: FIM Total at Finish - FIM Total at Goal Then calculate the Average value for FIM Goal attainment for each diagnostic category.
FIM Durability	To use a dataset, it must have a FIM assessment of score type Follow-up and a FIM assessment of score type Finish; the FIM total score for each assessment must have a non-null value. First calculate individual values for FIM Durability for each dataset within each diagnostic category: FIM Durability = FIM Total at Follow-up - FIM Total at Finish Calculate the Average FIM Durability for each diagnostic category.

Inpatient Rehabilitation Outcomes Report Topics	
Report Topic	Description
Diener SWLS Change	<p>To use a dataset, it must have a Diener's SWLS assessment of score type Start and a Diener's SWLS assessment of score type Finish; the Diener's SWLS score for each assessment must have a non-null value.</p> <p>Calculate individual values for Diener's SWLS Change for each dataset within each diagnostic category: $\text{Diener's SWLS Change} = \text{Score at Finish} - \text{Diener's SWLS Score at Start}$</p> <p>Calculate the Average value of Diener's SWLS Change for each diagnostic category.</p>
Diener SWLS Durability	<p>To use a dataset, it must have a Diener's SWLS assessment of score type Follow-up and a Diener's SWLS assessment of score type Finish; Diener's SWLS score for each assessment must have a non-null value.</p> <p>Calculate individual values for Diener's SWLS Durability for each dataset within each diagnostic category: $\text{SWLS Durability} = \text{Diener's SWLS at Follow-up} - \text{Diener's SWLS at Finish}$</p> <p>Calculate the Average value of Diener's SWLS Durability for each diagnostic category.</p>

Outpatient Rehabilitation Outcomes Report Topics Descriptions

Report Topic	Description
# and % of Patients	Number of patient datasets in the diagnostic category and Percentage of datasets in all diagnostic categories that number represents. % is the number of diagnostic datasets divided by number of all datasets.
Age (yrs)	Calculate of individual patient for each dataset in diagnostic category. Calculate Average patient age for each diagnostic category.
Age Range	Range of ages in datasets, from the age of the youngest person to the age of the oldest person for each diagnostic category.
Gender (% Male pts)	Percentage of males in diagnostic category.
Total FIM Change	To use a dataset, it must have a FIM assessment of score type Finish and a FIM assessment of score type Start; FIM total score for each assessment must have a non-null value. First calculate each individual's FIM Change for each dataset: Total FIM Change = FIM Total score at Finish - FIM Total score at Start Then calculate the Average value of FIM Change for each diagnostic category.
FIM Goal Attainment	To use a dataset, it must have a FIM assessment of score type Finish and a FIM assessment of score type Goal; FIM total score for each assessment must have a non-null value. First calculate the individual values for FIM Goal attainment for each dataset in the diagnostic category: FIM Total at Finish - FIM Total at Goal Then calculate the Average value for FIM Goal attainment for each diagnostic category.
FIM Durability	To use a dataset, it must have a FIM assessment of score type Finish and a FIM assessment of score type Follow-up; FIM total score for each assessment must have a non-null value. First calculate individual values for FIM Durability for each dataset within each diagnostic category: FIM Durability = FIM Total at Follow-up - FIM Total at Finish Calculate the Average FIM Durability for each diagnostic category.
Diener SWLS Change	To use a dataset, it must have a Diener's SWLS assessment of score type Finish and a Diener's SWLS assessment of score type Start; Diener's SWLS total score for each assessment must have a non-null value. Calculate individual values for Diener's SWLS Change for each dataset within each diagnostic category: Diener's SWLS Change = Score at Finish - Diener's SWLS Score at Start Calculate the Average value of Diener's SWLS Change for each diagnostic category.
Diener SWLS Durability	To use a dataset, it must have a Diener's SWLS assessment of score type Finish and a Diener's SWLS assessment of score type Follow-up; Diener's SWLS total score for each assessment must have a non-null value. Calculate individual values for Diener's SWLS Durability for each dataset within each diagnostic category: SWLS Durability = Diener's SWLS at Follow-up - Diener's SWLS at Finish. Calculate the Average value of Diener's SWLS Durability for each diagnostic category.

Continuum of Care Inpatient Outcomes Report Topics Descriptions

Continuum of Care Inpatient Outcomes Report Topics	
Report Topic	Description
# and % of Patients	Number of patient datasets in the diagnostic category and Percentage of datasets in all diagnostic categories that number represents. % is the number of diagnostic datasets divided by number of all datasets.
Age (yrs)	Calculate age of individual patient for each dataset in diagnostic category. Calculate Average patient age for each diagnostic category.
Age Range	Range of ages in datasets, from the age of the youngest person to the age of the oldest person for each diagnostic category
Gender (% Male pts)	Percentage of males in diagnostic category.
Length of Stay (days)	Length of Stay = Care Close Date - Care Start Date
Length of Stay Range	Range of length of stay from least number of days to most number of days within datasets used for each diagnostic category.
Total FIM Change	To use a dataset, it must have a FIM assessment of score type Finish and a FIM assessment of score type Start; FIM total score for each assessment must have a non-null value. First calculate each individual's FIM Change for each dataset: Total FIM Change = FIM Total score at Finish - FIM Total score at Start Then calculate the Average value of FIM Change for each diagnostic category.
FIM Efficiency	To use a dataset, it must have a FIM assessment of score type Finish and a FIM assessment of score type Start; FIM total score for each assessment must have a non-null value; the system must be able to calculate the Length of Stay. First calculate individual's FIM Efficiency for each dataset within each diagnostic category: FIM Efficiency = Total FIM Change / Length of Stay Then calculate the Average FIM Efficiency value for each diagnostic category.
FIM Goal Attainment	To use a dataset, it must have a FIM assessment of score type Finish and a FIM assessment of score type Goal; FIM total score for each assessment must have a non-null value. First calculate the individual values for FIM Goal attainment for each dataset in the diagnostic category: FIM Total at Finish - FIM Total at Goal Then calculate the Average value for FIM Goal attainment for each diagnostic category.
FIM Durability	To use a dataset, it must have a FIM assessment of score type Finish and a FIM assessment of score type Follow-up; FIM total score for each assessment must have a non-null value. First calculate individual values for FIM Durability for each dataset within each diagnostic category: FIM Durability = FIM Total at Follow-up - FIM Total at Finish Calculate the Average FIM Durability for each diagnostic category.

Continuum of Care Inpatient Outcomes Report Topics	
Report Topic	Description
Diener SWLS Change	<p>To use a dataset, it must have a Diener's SWLS assessment of score type Finish and a Diener's SWLS assessment of score type Start; Diener's SWLS total score for each assessment must have a non-null value.</p> <p>Calculate individual values for Diener's SWLS Change for each dataset within each diagnostic category: $\text{Diener's SWLS Change} = \text{Score at Finish} - \text{Diener's SWLS Score at Start}$</p> <p>Calculate the Average value of Diener's SWLS Change for each diagnostic category.</p>
Diener SWLS Durability	<p>To use a dataset, it must have a Diener's SWLS assessment of score type Finish and a Diener's SWLS assessment of score type Follow-up; Diener's SWLS total score for each assessment must have a non-null value.</p> <p>Calculate individual values for Diener's SWLS Durability for each dataset within each diagnostic category: $\text{SWLS Durability} = \text{Diener's SWLS at Follow-up} - \text{Diener's SWLS at Finish}$</p> <p>Calculate the Average value of Diener's SWLS Durability for each diagnostic category.</p>

Annual Evaluation Outcomes Report Topics Descriptions

Annual Evaluation Outcomes Report Topics	
Report Topic	Description
# and % of Patients	Number of patient datasets in the diagnostic category and Percentage of datasets in all diagnostic categories that number represents. % is the number of diagnostic datasets divided by number of all datasets.
Age (yrs)	Calculate age of individual patient for each dataset in diagnostic category; then Calculate Average age for each diagnostic category.
Age Range	Range of ages in datasets, from the age of the youngest person to the age of the oldest person for each diagnostic category.
Gender (% Male pts)	Percentage of males in diagnostic category.
Total FIM Score	To use a FIM assessment in this calculation, it must have a FIM Total score. Calculate the Average FIM Total Score for each diagnostic category.
Motor FIM Score	To use a FIM assessment in this calculation, it must have a FIM Motor score. Calculate the Average FIM Motor Score for each diagnostic category.
Cognitive FIM Score	To use a FIM assessment in this calculation, it must have a FIM Cognitive score. Calculate the Average FIM Cognitive Score for each diagnostic category.
CHART Physical Indep	To use a CHART-SF assessment in this calculation, it must have a CHART-SF Physical Independence Score. Calculate the Average CHART Physical Independence score for each diagnostic category.
CHART Cognitive Indep	To use a CHART-SF assessment in this calculation, it must have a CHART-SF Cognitive Independence Score. Calculate the Average CHART Cognitive score for each diagnostic category.
CHART Mobility	To use a CHART-SF assessment in this calculation, it must have a CHART-SF CHART Mobility Score. Calculate the Average CHART Mobility score for each diagnostic category.
CHART Occupation	To use a CHART-SF assessment in this calculation, it must have a CHART-SF Occupation Score. Calculate the Average CHART Occupation score for each diagnostic category.
CHART Social Interaction	To use a CHART-SF assessment in this calculation, it must have a CHART-SF Social Interaction Score. Calculate the Average CHART Social Interaction score for each diagnostic category.
CHART Economic	To use a CHART-SF assessment in this calculation, it must have a CHART-SF Economic Score. Calculate the Average CHART Economic score for each diagnostic category.
Diener SWLS	To use a Diener's SWLS assessment in this calculation, it must have a Diener's SWLS Total Score. Calculate the Average Diener SWLS Score for each diagnostic category.

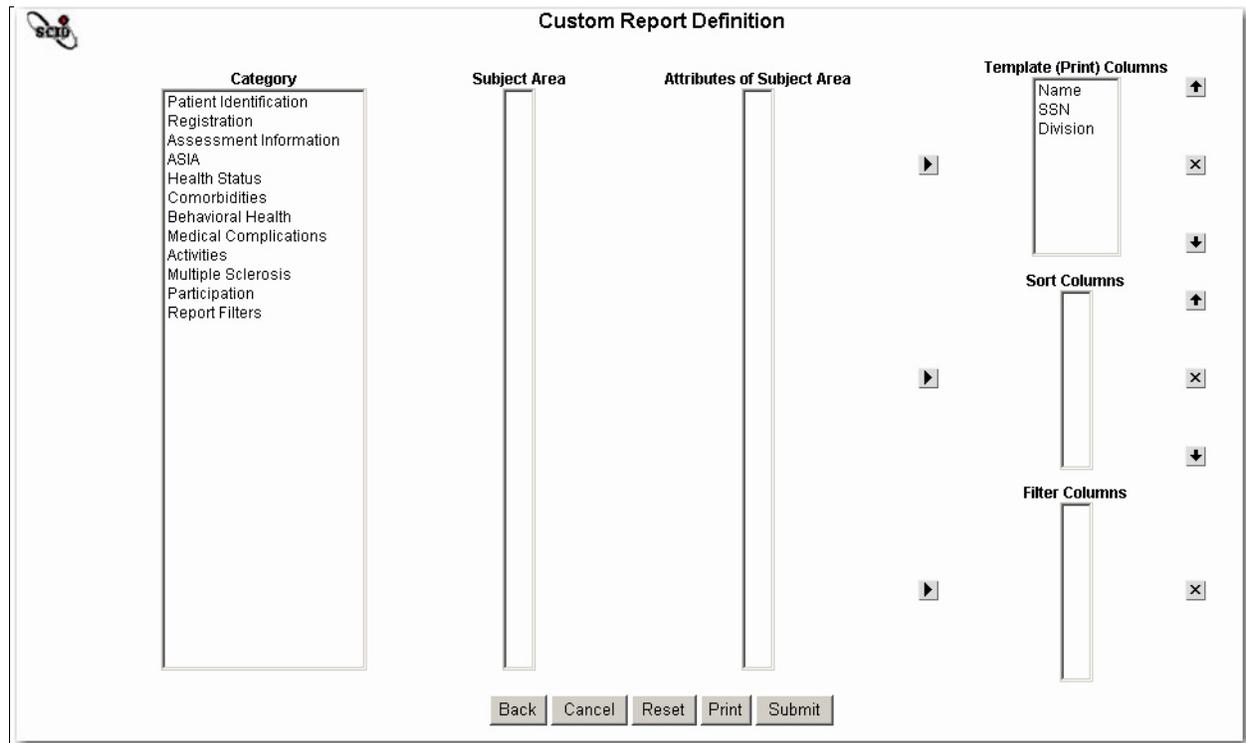
Custom Reports

You can generate custom reports to your specifications by learning to use the Report Designer, which allows you to select the criteria, format, and information needed for a report.

To generate a custom report, select the *Report Designer* button. Select a category and subject area of information to use in the report, and then select specific attributes to print in the report or to use as filters or sorting criteria. Sorting determines the order in which the rows of information occur. Filters allow the selection of specific portions of the population to be included in the report while excluding all others.

On the custom report definition page, a right arrow  allows movement of information from the attributes to be used in printing, sorting, or filtering. The  allows deletion of attributes from printing, sorting, or filtering. Up  and down  arrows are used to change the order of printed attributes or sorting criteria. Once filters have been selected, a second page will allow definition of values or ranges, if needed, for the selected filters.

When the Custom Report page first opens, it appears as follows with the categories listed and three print columns of Name, SSN, and Division already established. You can delete Name, SSN, or Division from the print column by selecting them and using the deletion function. 



Select the category, subject area, and attributes of subject area and add them to the print, sort, and filter columns, one at a time. As you select a category, the available subject areas for that category are displayed. After you choose a subject area, the available attributes become available.

In the example that follows, the Category ASIA was selected. Then the Subject area of ASIA was selected. From the ASIA attributes of subject area, ASIA Impairment was chosen and added to the Print, Sort, and Filter columns, using the arrows. From the ASIA attributes of subject area, Neurological Level was chosen and added to the print and filter columns using the arrows.

Select *Submit* to submit your custom report definitions. The Custom Filter Criteria window displays the filter options you selected in your definition. In the previous example, the filters selected were ASIA Impairment and Neurological Level. In the example below, we chose to highlight C as the only choice for ASIA Impairment and entered C07 for Neurological Level.

To select more than one ASIA Impairment filter criteria, hold down the Ctrl Key and highlight all desired filter criteria from the list. To select a range of filter criteria values, hold down the Shift key and select a beginning and end value. For example, for the ASIA Impairment, you could select “C” and then move down the list to “E”. For the ASIA Impairment list, there is a value of “UNK = Unknown” that is not visible in the example above, but can be viewed by scrolling down the filter list. Being able to select a range is useful when selecting from a large filter criteria list. For some criteria, such as the Neurological Level, there is no list to choose from, and values must be entered accurately.

After selecting the *Submit* button, the Custom Report Results are displayed. The Custom Report Result page shows the Template (Print) Columns that were selected on the Custom Report Definition page. The report parameters, including the filters used as criteria, are displayed at the bottom of the report.

The screenshot shows a web application window titled "Custom Report Result". At the top, there is a logo on the left and three buttons: "Back", "Cancel", and "Print". Below the buttons is a table with five columns: "Name", "SSN", "Division", "ASIA Impairment", and "Neurological Level". The table contains three rows of patient data. Below the table, there is a section titled "Report Parameters" with a numbered list of six items. At the bottom of the window, there is a link for "Export options: CSV | Excel".

Name	SSN	Division	ASIA Impairment	Neurological Level
SPINALCORD,SIXTEEN	000000016	CHEYENNE VAMC (442)	C = Incomplete: Motor function is preserved below the neurological level, and more than half of key muscles below the neurological level have a muscle grade less than 3	C07
SPINALCORD,NINETEEN	000000019	CHEYENNE VAMC (442)	C = Incomplete: Motor function is preserved below the neurological level, and more than half of key muscles below the neurological level have a muscle grade less than 3	C07
SCDTESTPATIENT,FOUR	666040004	CHEYENNE VAMC (442)	C = Incomplete: Motor function is preserved below the neurological level, and more than half of key muscles below the neurological level have a muscle grade less than 3	C07

Report Parameters

1. Date/Time Run = Thu Jun 14 16:26:57 CDT 2007
2. Divisions filtered by Role = CHEYENNE VAMC (442), CHEYENNE VAMC (983), DAYTON (984)
3. Report Created by = User Gui Sciclinician
4. User's Role = SCI_Clinician
5. ASIA Impairment = C
6. Neurological Level = C07

Export options: [CSV](#) | [Excel](#)

If there are no report results, the System returns a message that “Your filter criteria returned no patients. Please check your selections and try again.”

You have the option of exporting the report results into a comma-separated value (CSV) file format or into an Excel spreadsheet format using the Export Option commands [CSV](#) and [Excel](#) at the bottom of the report.

From the Custom Report Result page, select *Cancel* to return to the Reports tab. The *Back* button will take you back to the Custom Filter Criteria page, where you can re-select filter criteria, then rerun the report. It is often prudent when rerunning reports to return to the Reports tab to reselect all the criteria, rather than using the *Back* function.

Index

Access and Permission.....	9, 69	Assessment(s).....	49
Activate		activating or inactivating.....	72
assessment(s).....	69, 72	blank forms.....	53, 56
episode(s) of care.....	72	button functions.....	53
patient status.....	69, 71	creating.....	54
Activities Tab.....	2	editing.....	55
Additional Care VA		entry forms.....	85
filter.....	66	follow-up score type.....	30–31
Administration tab.....	69–74	forms.....	85–115
Administration Tab.....	3	header.....	29, 52, 53, 52–53
Administrator role.....	69, 70	header fields.....	29
Admissions (SCI&D) report.....	61	in SCIDO application.....	7–8
Age		on Impairments tab.....	34
filter.....	66	versus instrument.....	35
in tab header.....	3	Attendant Care.....	48
Aggregate report.....	<i>See Reports, Cumulative</i>	hours of assistance on CHART-SF.....	94
Alcohol Abuse.....	<i>See AUDIT and CAGE</i>	Interruptions.....	48
Alcohol Use Disorders Identification Test (AUDIT)....	7, 34	loss admissions.....	48
assessment form.....	89–90	AUDIT.....	<i>See Alcohol Use Disorders Identification Test</i>
used with CAGE.....	92	Audit Log report.....	76
American Spinal Injury Association Standard Neurological		Back function.....	53
Classification of Spinal Cord Injury.....	<i>See ASIA</i>	Basic Patient Information report.....	62
Ancillary Data Entry form.....	22, 116–17	Benchmarks	
Fields		CHART-SF.....	49
Additional Care VAMC.....	116	FIM.....	43, 44, 47
BCR Certified.....	117	MSCIS.....	49, 130
BCR Provider.....	117	SWLS.....	47
Bowel Care Reimbursement (BCR).....	117	Bladder Accident Frequency.....	7, 44, 109
Initial Rehabilitation Discharge Date.....	117	Bladder Drainage.....	39
Initial Rehabilitation Site.....	117	Body Mass Index (BMI).....	7, 34
Non-VA Care.....	116	assessment form.....	91
Referral Source.....	116	description.....	33–34
Referral VA.....	116	Bowel Accident Frequency.....	7, 44, 109
Remarks.....	117	Bowel Care Reimbursement (BCR).....	117
Annual Evaluation		Breakdown of Patients report.....	62
information on Registration tab.....	15, 20	CAGE (Cut Down, Annoy, Guilt, Eye-Opener).....	7, 34
Next Due		assessment form.....	92
filter.....	66	Calculate function.....	54
in tab header.....	3	Calendar.....	4, 54
on Registration tab.....	20	Cancel function.....	11, 54
Annual Evaluation Outcomes report.....	61, 129, 135	Care Close Date	
Annual Evaluation VAMC		episode of care.....	27
filter.....	66	previous episode(s) of care.....	28
Registration tab.....	20	Care Start Date	
Applications for Inpatient Care report.....	61	episode of care.....	25, 26, 27
ASIA.....	7, 34	on assessments.....	29, 52, 53
assessment form.....	86–88	previous episodes of care.....	28
Complete/Incomplete.....	86, 88	Care types.....	52, 55
impairment scale		episode of care.....	25, 26, 27, 29
filter.....	66	Catastrophically disabled.....	24
in tab header.....	3	Catchment.....	<i>See SCI region</i>
on ASIA form.....	86, 88	Category of Injury filter.....	66
on Registration tab.....	17	Cause of Injury filter.....	66
Information Section on Registration tab.....	15, 16–17	Center for Epidemiologic Studies Depression Scale	
neurological level		(CES-D).....	7, 34
filter.....	66	Center for Epidemiologic Studies Depression Scale (CES-	
in tab header.....	3	D) form.....	93
on ASIA form.....	86, 88	CES-D.....	<i>See Center for Epidemiologic Studies Depression</i>
on Registration tab.....	17	Scale	
recommended to be entered first.....	29	CHART-SF.....	7, 51

assessment history.....	49	Trauma or Non-Trauma.....	18
progress notes	<i>See Progress Notes</i>	Expanded Patient Listing report.....	62
subscales	49	FAM.....	<i>See Functional Assessment Measure</i>
Check Your Health (CYH)	7, 34	Fee Basis filter.....	67
assessment form.....	97–98	FIM	<i>See Functional Independence Measure (FIM)</i>
clinician role	70	Follow-Up (Last Seen) report.....	63
Community Discharges report	61	Follow-up date	28–29
Continuum of Care Inpatient Outcomes report.....	61, 129, 133–34	Follow-Up Last A.E. Received report.....	62
Coordinator, SCI.....	22, 70	<i>FSS.....</i>	<i>See Kurtzke Functional Systems Scale (FSS)</i>
Copyright information	83–84	Function Related Group (FRG).....	106
County, filter.....	66	Functional Assessment Measure (FAM)	7, 44
Cover Sheet tab.....	2, 13	assessment form	104
Craig Handicap Assessment and Reporting Technique ..	<i>See CHART-SF</i>	Functional Independence Measure (FIM)	7, 43
Cumulative Reports	<i>See Reports, cumulative</i>	assessment form	105–6
Current Inpatients report.....	62	average change.....	130
Custom reports.....	<i>See Reports, custom</i>	change	132
CYH.....	<i>See Check Your Health (CYH)</i>	cognitive score	44
Date of Death field.....	23, 24	durability	130, 132, 133
Definitions	79	efficiency.....	130, 133
Deployment Guide, SCIDO	1	filter.....	68
Diagnoses.....	41, 42	goal attainment.....	130, 132, 133
Impairments & Medical Complications reports	60	motor score.....	44
on Cover Sheet.....	2, 13	polar graph	106
on Urinary Tract Infections report	126	progress notes.....	<i>See Progress Notes</i>
pneumonia or atelectasis	38	Geographic Area filter.....	67
pre-existing	5, 34	Graphs	
secondary	2, 5, 34	Activities tab	43
urinary tract.....	39	FIM Polar	106
Diagnosis or Health Problem field.....	101	Impairments tab.....	33
Diagnostic Categories, cumulative reports.....	129	Medical Complications tab.....	37
Diener's SWLS	<i>See Satisfaction with Life Scale (SWLS)</i>	Participation & SWLS tab.....	47
Discharges (SCI&D) report	62	Help.....	4, 54
Division filter.....	66	History fields.....	5
Drug Abuse Screening Test (DAST)	7, 34	Home Maintenance, hours per week	51
DUSOI.....	7, 34	Homemaking, hours per week.....	51
DUSOI-A.....	7, 35	Hours of Help filter	67
assessment form.....	103	Household, number in	48
EDSS	<i>See Kurtzke Expanded Disability Status Scale</i>	ICD Code Search report	62
Education		ICD Search.....	101
form	<i>See Patient Education form</i>	Impairments	
on Participation tab	50	and Medical Complications reports.....	60–61
on Registration tab	21	reports.....	59
report.....	62	tab.....	2, 33–35
Employment status.....	50	Import Record	69, 70, 71
Employment, hours per week	51	Inactivate	
Enrollment Priority	24	assessment(s).....	69, 72
EoC Close Date.....	<i>See Care Close Date</i>	episode(s) of care	72
EoC Start Date	<i>See Care Start Date, episode of care</i>	patient status.....	69, 71
Episode of Care.....	22	Influenza.....	2, 38
activation or inactivation.....	72	Diagnoses and Treatment report.....	60
close date	27	Immunizations report	60
closing.....	27	Influenza Diagnoses and Treatment Report	120
creating	26–27	Influenza Immunizations Report.....	121
follow-up date.....	28–29	Information Resource Management (IRM)	
previous	28	monitoring of system activities	76
start date.....	<i>See Care Start Date</i>	role	69, 70
Ethnicity filter.....	68	tab.....	75–77
Etiology		Tab	3
filter	66	Inpatient Outpatient Activity report	63
information on Registration tab	15, 18–20	Inpatient Outpatient Specific at Your Division report.....	63

Institutional view	70	Occupation and Education.....	50–51
Instrument(s).....	<i>See also</i> Assessment(s)	Patient Education form.....	22, 118
in SCIDO application.....	7–8	Patient Education report.....	62
versus assessment	35	Patient Listing by State and County report.....	63
Instruments	85	Patient Listing report.....	63
Integration Control Number (ICN).....	69, 72	Patient listing(s) reports	61–62
IRF-PAI	7, 109	Patient Lookup	3
IRM	<i>See</i> Information Resource Management	Patient search	3, 9
Kurtzke Expanded Disability Status Scale (EDSS)	7	Patient status	69, 71
assessment form.....	107	Patient Summary report.....	62
Kurtzke Functional Systems Scale (FSS)	7	Patients with Future Appointments report.....	62
assessment form.....	108	PDF	<i>See</i> Assessment(s), blank forms
Lab Utilization (Specific) at Your Division report	63	Pharmacy Utilization at Your Division report.....	63, 64
Laboratory Utilization at Your Division report.....	63	Pneumococcal Immunizations report	60, 124
Locked Records	76	Pneumonia and Respiratory report	37–38, 60, 123
Login.....	9	Pneumonia on Medical Complications tab	37–38
Logout.....	3	Pressure Ulcer Scale for Healing (PUSH).....	8, 40
Mail Groups.....	69, 73	assessment form	111
Mailing Labels report.....	63	Pressure Ulcer(s)	39–41
Master Patient Index (MPI)	72, 75	Finish section	41
McGill Pain Questionnaire	<i>See</i> Short Form McGill Pain	PUSH instrument....	<i>See</i> Pressure Ulcer Scale for Healing
Questionnaire (SF-MPQ)		(PUSH)	
Medical Complications reports	59	report	60, 126
Medical Complications tab	2, 37–42	Risk section	40
Pain section.....	42	stage in tab header	3
Pressure Ulcer Finish section.....	41	Primary Care information on Registration tab.....	15, 18
Pressure Ulcer Risk section	40	Primary Care VA filter.....	67
Medical Needs Function Modifiers.....	7, 34, 44	PRIME-MD.....	8, 35
assessment form.....	109	assessment form	110
bladder accidents frequency rating.....	44	Print function.....	4, 53
bowel accident frequency rating	44	Procedures, pre-existing	34
Medications filter.....	67	Progress Notes.....	56–58
Metro/Micro/Rural.....	49	Prosthetics filter	67
MNFM.....	<i>See</i> Medical Needs Function Modifiers	Prosthetics Utilization (Specific) at Your Division report	64
Motor Key Muscle fields	<i>See</i> ASIA, assessment form	Prosthetics Utilization at Your Division report	64
MS (Kurtzke) Measures report	63	PUSH	<i>See</i> Pressure Ulcer Scale for Healing (PUSH)
Multiple Sclerosis	2	Race filter	67
EDSS	<i>See</i> Kurtzke Expanded Disability Status Scale	Radiology Utilization at Your Division report	64
etiology	19	RAI-MDS.....	61
filter	67	RAI-MDS Quality Indicators Report	127
FSS	<i>See</i> Kurtzke Functional Systems Scale (FSS)	RAI-MDS Resource Utilization Groups (RUGS) Report	128
mail group.....	3, 69, 73	Readmissions report.....	62
report.....	<i>See</i> MS (Kurtzke) Measures report	Recreation, hours per week	51
subtype.....	19	Regional attributes	3, 70, 75
National/Regional Update.....	77	Regional view.....	70
Neuro. Level	<i>See</i> ASIA, neurological level	Registration Ancillary Data Entry form .	<i>See</i> Ancillary Data
Neurological Classification of Spinal Cord Injury	<i>See</i> ASIA	Entry form	
Neurological Level!"	<i>See</i> ASIA, neurological level.....	Registration Status	15, 16
New SCI&D Patients report.....	63	filter.....	68
Occupation		Registration tab	2, 15–16
at Injury.....	51	Additional Information Section	20–22
current.....	51	Annual Evaluation Information Section	20
Occupation and Education	50–51	ASIA Information section	16–17
Outpatient Rehabilitation Outcomes report.	61, 129–31, 132	Etiology Information Section	18–20
Outpatient Visit filter	67	Primary Care Information	18
Pain.....	2, 37, 42, 114	Registration and Network Section.....	16
Assessment and Treatment report.....	60, 122	required fields.....	15
SF-MPQ.....	8	Report Designer	<i>See</i> Reports, custom
Participation & SWLS tab	2, 47–51	Reports	
assessments	49	cumulative	59, 61, 129–35
attendant care	48	custom	2, 59, 60, 136–38
CHART-SF subscales	49	export options.....	60

filtered.....	59, 68	Annual Evaluation, Offered.....	20
filters.....	64–68	Annual Evaluation, Received.....	20
patient listing(s).....	59, 61–62	ASIA.....	3
tab.....	59–68	Bladder Drainage.....	3, 39
Tab.....	2	Brain Injury.....	34
Required fields		Current Occupation.....	51
marked on assessments.....	52	Date Changed.....	16
Researcher role.....	70	Date of Birth.....	3
Reset function.....	4, 54	Date of Death Field.....	24
Roles.....	69, 70	Date of Last Review.....	23
Sample DUSOI		Date of Onset.....	19
assessment form.....	100–102	Dehydration Signs.....	34
satisfaction with Life Scale (SWLS).....	8, 49, 131	Describe Other.....	34
assessment form.....	112	Describe Other Etiology.....	19
progress notes.....	<i>See Progress Notes</i>	Education.....	3, 50
School, hours per week.....	51	Employment.....	3
SCI Network.....	15	Employment Status.....	50
filter.....	68	Enrollment Priority.....	24
SCI Network?.....	16	Etiology.....	19
SCI region(s)		Etiology History.....	20
on Administration tab.....	70, 73	Finish Record Date.....	41
SCI Network.....	15	First Seen in VA for SCI.....	22
SCIDO Outcomes Coordinator.....	<i>See Coordinator, SCI</i>	Highest Level of Education.....	21
SCI region(s)		Highest Neurological Level.....	17
on Administration tab.....	69	Historic SCI&D Outcomes Coordinators.....	22
on IRM tab.....	76	Impairment Scale.....	17
Score type(s)		Is Ulcer Closed/Healed.....	41
episode of care.....	25, 26, 27, 29	Last Updated By.....	24
finish.....	27, 30, 53	Medical Centers Visited.....	24
follow-up.....	30, 53	Metro/Micro/Rural.....	23
goal.....	27, 30, 53	MS Subtype.....	19
interim.....	30, 53	Name.....	3
on assessments.....	29, 53, 55	Network History.....	16
start.....	30, 53	Neurological Level.....	3
unknown.....	30, 53	Next AE Due.....	3
Secondary Conditions Checklist.....	<i>See Check Your Health (CYH)</i>	Occupation at Injury.....	51
Secondary conditions, on Impairments tab.....	34	Occupation at Time of Injury.....	21
Section 508 Compliance.....	1	Other Injury.....	34
Sensory Point fields.....	<i>See ASIA, assessment form</i>	Predominant Position at Finish.....	41
Separate window.....	<i>See Window Expander Icon</i>	Pre-Existing Diagnoses.....	34
Service Connection filter.....	68	Pre-Existing Procedures.....	34
Sex filter.....	68	Pressure Ulcer (stage).....	3
SF-8 Health Survey.....	8, 35	Pressure Ulcer Finish History.....	41
assessment form.....	113–14	Pressure Ulcer Risk.....	40
Short Form McGill Pain Questionnaire (SF-MPQ).....	8, 42	Primary Care Provider.....	18
assessment form.....	115	Primary Care VA Medical Center.....	18
Social section, Participation tab.....	48–49	Registration (Status).....	16
State filter.....	66	Registration Date.....	23
Submit function.....	4, 54	Risk Instrument History.....	40
assessment.....	55	Risk Instrument Used.....	40
progress note.....	58	Risk Record Date.....	40
Substance abuse assessments		SCI Network?.....	16
Alcohol Use Disorders Identification Test (AUDIT).....	89	SCI&D Outcomes Coordinator.....	22
CAGE.....	92	Secondary Conditions.....	34
System Activities.....	76	Service-Connected for SCI.....	21
Tabs		SF-MPQ History.....	42
Fields		Sitting Time.....	41
Age.....	3	Social Security Number.....	3
Amount VA is Used.....	22	Student History.....	50
Annual Evaluation VAMC.....	20	Student?.....	50
Annual Evaluation, Next Due.....	20	Swallowing Status.....	34
		Time to Achieve Healing.....	41

Trauma or Non-Trauma	18	VA Service Desk.....	1
VA SCI Status.....	24	Verify Code.....	9
Ventilator Equip./Supplies	37	VHA National SCI Help Desk	1
Veteran's Home Address	23	VistA	
Volunteer	50	document library	1
header (of tabs)	3	installation guide	1
Urinary Tract Infections		report information	38, 39, 41
Impairments tab	38-39	Vitals application.....	37, 42
report.....	60	Vital Status filter	68
Urinary Tract Infections Report.....	126	Walk/Wheelchair filter.....	68
User Role	See Roles	Window Expander Icon.....	5
VA SCI status	24, 63	Zip Code filter.....	See Geographic Area filter